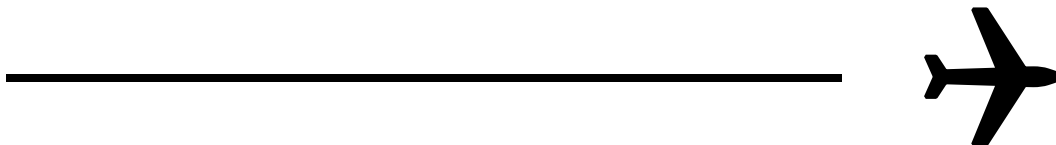


CDC 4C051N

Mental Health Journeyman

Volume 3. Mental Health Evaluation and Psychometric Fundamentals



Extension Course Program (A4L)
Air University
Air Education and Training Command

4C051N 03, 0907, Edit Code 03
AFSC 4C051

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THIS 4C051N CDC, *Mental Health Journeyman*, will build on the foundation began in the apprentice course providing greater insight into the evaluation and psychometric assessment functions. You will also explore two common addiction models as well as the pharmacology of abused substances. This volume will close with an overview of the common psychometric assessments you will be expected to perform in your job as a mental health journeyman.

Unit 1 guides you through the process and gives you the skills necessary for a patient initial evaluation. A comprehensive examination of common terms and definitions, as well as the specific requirements necessary for a thorough assessment will be discussed in this unit.

Unit 2 focuses solely on the world of substance use. Beginning with two common addiction models, you will delve into the many physiological implications of substance abuse as well as the pharmacological makeup of each. The dysfunctional nature of chemically dependent families and dual diagnosis will close out this unit.

Unit 3 is dominated with psychometric tests and inventories. This will provide you with a launching platform as you begin honing your skills in administering psychometrics.

A glossary of abbreviations and acronyms used in this course is included at the end of this volume. Code numbers on figures are for preparing agency identification only.

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This volume is valued at 12 hours and 4 points.

NOTE:

In this volume, the subject matter is divided into self-contained units. A unit menu begins each unit, identifying the lesson headings and numbers. After reading the unit menu page and unit introduction, study the section, answer the self-test questions, and compare your answers with those given at the end of the unit. Then do the unit review exercises.

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Unit 1. Skills for Patient Evaluation

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THIS UNIT will focus entirely on identifying and using the skills you’ll need to perform patient evaluations. Some of you may have had little opportunity to employ the patient evaluation skills taught to you in the apprentice course. Training, time, and exposure to patient assessments are essential in your development of interviewing skills. As you proceed through this course, you should carefully study each lesson; as it is imperative that you are not only confident in what you are about to embark on, but also competent. Keep in mind; although all of the administrative tasks, research, and psychometric examinations you perform or book knowledge you gain will never fully prepare you for a face-to-face interview with a patient, it will give you the tools you need to perform this aspect of your job with more skill and confidence.

1–1. Interviewing Skills, Principles, and Techniques

There is no single right or wrong way to conduct an interview. In fact, there are many different approaches used to evaluate patients. Therefore, it’s important to expose yourself to a variety of approaches, tools, and tips of the trade so you have a large pool of skills to draw from when working with patients. Improving your skills will help prepare you to work in a variety of settings and with a variety of patients.

Throughout this lesson you will see the terms *interviewer*, *journeyman*, and *clinician*. In this lesson they are all synonymous since your job as a Mental Health Journeyman and clinician will require you

to interview patients. Your role as a Mental Health Journeyman in interviewing patients is one of the most challenging and rewarding aspects of this career field. Nowhere else will your skills be tested or your understanding of the mental health process be evaluated so completely. In the interview, some patients reveal intimate, private, and painful experiences. Others present themselves as highly motivated, with the hope of relieving their suffering; yet they may consciously and unconsciously conceal their innermost feelings, which they perceive to be shameful or threatening. Many patients are laboring under difficult personal problems and are typically worried, anxious, depressed, discouraged, and otherwise emotionally upset. Often, patients will withhold information if they think the interviewer will think less of them as a person. Patients who are involuntarily referred complicate the interview process even more when they are not willing to cooperate.

The *intake* interview is the first step in helping patients. This initial interview may be difficult, but there is nothing mysterious about it. Your skill and professionalism in conducting the interview will strongly influence the type of therapeutic relationship that develops. In addition, the skills used in an intake interview can be applied to other clinical interviews. These skills usually develop best with experience, especially when that experience is professionally supervised.

401. Improving interviewing skills

For some of you, the thought of conducting a face-to-face interview with a patient is terrifying! What will I say? What should I do? What if I get stuck? You begin to doubt your own capabilities and lose sight of the fact that the patient is there to see you to simply talk to you. Don't make it any more formal than that. The interview process is not a scientific project. If you treat it as such, it will be perceived as more of an interrogation than a clinical interview, and your patient will likely be scared as well. Keep in mind, the patient is likely to be anxious and intimidated about an unfamiliar process and coming into a clinic and revealing personal information to a complete stranger.

I like to refer to the process of an interview as an orchestrated conversation. Not just anyone can conduct a patient interview. It takes a blend of knowledge, training, experience, and personality to make it all come together just right. Let's begin by looking at some *characteristics* that you as a Mental Health Journeyman will find useful in conducting a good interview.

Self-awareness

First and foremost, the journeyman must have self-awareness. As a counselor you must be aware of your own biases. You could sabotage an interview and diminish patient confidence by projecting biases or reacting negatively to patients problems. Consequently, a lack of self-awareness can limit your ability to be accepting of a patient. As you've learned in volume 1 of this course, there are unique cultural, religious, ethnic, and gender differences each of us possess. These factors will influence how we interact with patients—how patients respond to us and how we respond to patients. It is imperative that you know your limitations and educate yourself on issues that are unfamiliar to you.

Acceptance

Acceptance is the second important interviewing characteristic of a journeyman. This is often a problem for the novice or inexperienced journeyman as the patient often reports behaviors or expresses attitudes or feelings that might be socially unacceptable. When you are able to demonstrate acceptance to the patient, it simply means you are withholding judgment of the patient. Conduct the interview in a way that conveys to the patient that you regard what the patient is saying or feeling as being true. It does not imply that you necessarily embrace the same beliefs or condone a particular behavior. In fact you may find you feel angry or repulsed by some revelation the patient has revealed. Keep in mind that you are unlikely to establish any type of rapport with a patient if the interview digresses into an argument. It does serve to recognize the patient's pain as he or she experiences it, and validates that his or her problems are real and deserving of attention.

Observation

To conduct a good interview, Mental Health journeymen must be good observers. Being a good observer primarily means you are able to take in the entire situation and read many different things simultaneously. For instance, you will be expected to watch the general body movements of a patient and cue in when those movements are influenced by perhaps the topic of the conversation, the patient's situation, the patient's feelings, or even some underlying pathology. Being a good observer takes practice and confidence in identifying what you are observing.

Being observant also includes developing good listening skills. Remember, an interview is an opportunity for the patient to talk about what brought him or her to the clinic. Some novice journeymen feel if they aren't constantly speaking or in motion, they are doing something wrong. It is impossible to listen effectively if you are speaking at the same time. I think it's no coincidence that the same letters used to spell the word *listen* are also in the word *silent*. It is important to the patient that you are also capable of hearing what is *not* being said. Listen "between the lines" so to speak, and hear what the patient is unable to say directly. We will discuss this later as we delve into the many facets of a Mental Status Examination (MSE). The point is, if you, as the interviewer, fail to be observant or have poor listening skills, you might miss this opportunity to learn something new about the patient.

Empathy

Another important characteristic the journeyman must possess is the ability to convey empathy. Empathy is acknowledging how a patient feels without actually feeling the same way. You should attempt to understand what the patient is feeling while remembering that you're not likely to be helpful if you adopt the patient's emotions (frustration, anger, discouragement, etc.). Differentiating between empathy and sympathy can be a difficult boundary to maintain for an inexperienced journeyman. Patients experiencing bereavement, victims of family violence, sexual assault survivors are a few examples of exposure to instances that can be a very personal and emotionally draining interview. Practice and exposure to a variety of interviews will help build your confidence and competence in this area.

Qualities of the therapeutic relationship

The interviewer-patient relationship is distinguished from other types of relationships. We identify marriage as an intimate relationship. We may have coworkers we consider friends, or we have acquaintances that are casual relationships. The interviewer-patient relationship is similarly defined. When a patient initiates contact with the journeyman with the intent of receiving some form of psychotherapeutic intervention, the association is referred to as a therapeutic relationship. As you can see, the purpose of the association very clearly defines the relationship. Let's look at some of the factors that can influence the quality of the therapeutic relationship.

Rapport

Rapport is defined as a relation of mutual understanding or trust and agreement between people (or you the interviewer and the patient). Rapport is the primary basis for all successful communication. Establishing rapport in a therapeutic relationship allows the patient to feel confident about the interviewer's competence. Rapport should not be confused with whether or not the patient "likes" the interviewer. Most of us have several people in our lives we like quite well, but we don't know them well enough to give them our trust implicitly. However, we are asking the patient to give us his or her implicit trust—what an incredible responsibility!

Despite your best efforts to establish rapport, the fact is, some patients will definitely not like you. Inherently, this job calls the journeyman to, at times, help people face things in their lives or about themselves that are either unpleasant or uncomfortable. This more often occurs when the patient is directed to undergo or participate in a command-directed evaluation, substance abuse assessment, or

when there is an allegation of family violence. Maintaining rapport and avoid having the interview digress into a debate or verbal conflict will be challenging, yet essential in these cases.

It is through the interview process that we begin to establish rapport. Earlier you read information about the characteristics of the interviewer. Those same characteristics help not only to establish rapport, but also to maintain it for the duration of the therapeutic relationship.

Therapeutic alliance

Initially, the patient will view the interviewer as the authority figure. This should disappear as you begin to employ the interviewing skills you studied earlier in this lesson. At the beginning of this lesson, I referred to the interview as an orchestrated conversation. This is true; as an alliance begins to form, it is evident that the interviewer is more of an ally than a superior. It is important that the patient comes to view the interviewer as an ally for two reasons. If the interviewer remains in a position of authority, the patient will become increasingly dependent upon the interviewer and expect the interviewer to solve the patient's problems for him or her; the patient may continue to avoid taking responsibility for his or her life. Neither of these is good for the patient, as they prevent the patient from experiencing any degree of personal growth and eventual recovery. Secondly, it is critically important that the interviewer establishes an alliance with the patient. This will help the patient to understand that we are working as a team, in unison, and for a common goal. It will also help the patient understand that he or she must take an active role in the process of improving his or her situation or emotional health.

Transference

Transference is the process in which the patient unconsciously projects emotions, thoughts, and expectations related to important people in the past onto an important authority figure like the interviewer. It is important that you recognize these patterns of behavior and deal with these distortions of reality appropriately.

Counter-transference

Counter-transference occurs when the interviewer unconsciously projects emotions, thoughts, and expectations from past life experiences onto the patient. These reactions are inappropriate in a patient-interviewer relationship because they interfere with the interviewer's understanding of the patient.

General information

Generally speaking, there are several characteristics that help a journeyman be successful in conducting a good interview. A journeyman must be mature, professional, have a strong knowledge base, and be competent. The journeyman must be well-versed in the ethical responsibilities of patient care. However, being self-aware, capable of conveying acceptance, being observant, and possessing empathy are critical characteristics. The therapeutic relationship is doomed to failure without these important characteristics.

402. Interviewing principles and techniques

There are certain principles and techniques, when used appropriately, that build a therapeutic relationship and assist in obtaining needed information from patients. The principles and techniques selected for review in this lesson are interrelated and often compliment one another. In using these principles and techniques, try to capture the intended content and meanings of what patients say explicitly. Also, be keenly attuned to any nonverbal cues patients exhibit as well. Gestures, posture, facial expressions, attire, and other aspects of physical appearance can often provide useful clues to the patients' feelings and thoughts about themselves, others, or life's circumstances.

Attending behaviors

Interviewing a patient requires your undivided attention if you are to gather accurate information and demonstrate genuine concern. Attentiveness is a state of mind that can be fostered by certain

behaviors. Attending behaviors help you to follow closely what the patient says and does. These behaviors express to the patient: “I’m paying attention to what you say; I understand what you say; I care about you as a person.” Three behaviors that serve these purposes well are eye contact, attentive posture, and verbal following.

Make eye contact

Eye contact is very much involved in communication. The interviewer who does not look at the patient will fail to observe potentially significant nonverbal expression. Rapport will also suffer because the interviewer will seem inattentive and uncomfortable. However, eye contact should not come across as fixed staring. It should be a natural visual contact with the patient, which puts both the interviewer and patient at ease.

Display attentive posture

The comfortable interviewer is relaxed and seated naturally. Movements and gestures should indicate close attentiveness to what the patient is saying. Leaning forward and towards the patient, for example, can demonstrate interest and attentiveness. The point to remember is that the interviewer, like the patient, communicates with “body language” as well as through words.

Use verbal following

Verbal following means responding verbally to what is being said without changing the subject. When using verbal following, the interviewer may employ any number of responses, e.g., asking a question, making a statement, or just repeating a few of the patient’s words. The key to verbal following is that the response made does not change the subject of the conversation. It communicates to the patient “I am with you.” It is also used to encourage the patient to continue talking about the subject.

Specific skills

Counselors use specific skills when interviewing or assessing patients. The following discusses some of the skills you can use to refine your own interviewing and skills and techniques.

Questioning techniques

The way in which questions are asked can have a great influence on the quantity and quality of responses. The type of response received often depends on the way in which a question is asked.

- Begin with questions that center on the patient’s concerns. The best questions come from what the patient has already said, not from the interviewer’s curiosity.
- After a question, pause and give the patient enough time to respond. If the patient feels a quick response is needed, you may not get the best or correct response.
- Use simple questions. Most inexperienced interviewers tend to ask several questions before giving the patient a chance to respond. For example, “How many hours of sleep a night are you getting? I mean, do you go right to sleep or do you wake up throughout the night or are you only sleeping a few hours a night?” This practice confuses the patient who may answer the question that is of least importance. Simple questions are direct and allow the patient the opportunity to focus on one issue at a time. For example, “Tell me about your sleeping habits.”
- Realize that using questions as the only means of gathering information is shortsighted. Overuse of questions can make a patient feel threatened, intimidated, or interrogated and not meet his or her emotional needs. The types of question used in the interview will depend primarily on the patient, situation, and information needed.

Be clear

The interview is not an appropriate setting to dazzle patients with technical terms. Language used in the interview should be consistent with the patient’s language. The military environment is the worse

offender when it comes to the common use of acronyms to communicate. “My DEROS to return CONUS is the first day of the next FY. I’m hoping to get my PCS orders amended so I can go TDY to ALS en route.” Did you understand all of that? You may have, but your patients may be completely baffled if you engage in a conversation using acronyms they may not be familiar with or understand. There are times when it is appropriate or necessary to use military terms or slang expressions; however, this must be done very cautiously. An attempt to win the patient’s confidence by imitating dialects or speech patterns you don’t normally use could embarrass the patient rather than put him or her at ease.

Use open-ended questions

Open-ended questions are usually the best to use because they give the patient many avenues for self-expression. These questions are used whenever an interviewer wants the patient to express thoughts and feelings freely. A good example of an open-ended question is, “What brought you into the clinic today?” This type of questioning often allows the patient to relax and not feel pressured to come up with the *right* answer. The most effective open-ended questions are those beginning with words like *who*, *what*, *where*, *when* or *how*. *Why* questions can be accusatory or antagonistic and you can obtain the same information by asking “what” instead of “why.”

As you can see, using open-ended questions provide the patient an opportunity to tell his or her “story.” This is useful except when the patient is overly talkative. Open-ended questions should be limited in this instance as you run the risk of never completing the interview or have difficulty controlling the direction of the interview.

Use close-ended questions sparingly

Close-ended questions are more limiting than open-ended questions. They are used to elicit brief, factual answers. Close-ended questions typically elicit little more than a yes or no response from the patient. It’s best to use close-ended questions sparingly and follow them with open-ended questions. Too many close-ended questions, especially in the beginning of an interview, can lead to limited responses. Also, use of close-ended questions with hostile or depressed patients can make the task of gathering information very difficult. Close-ended questions typically start with words like *is*, *are*, *do*, or *did*. As you can see, these questions can be easily answered without clarification.

Ask appropriate questions

Above anything else, the questions asked in the interview should be pertinent to the patient’s situation and consistent with the goals of the interview. For example, if your patient works in the Financial Services Office and is in your office discussing his or her pending divorce, it’s inappropriate for you to ask about your recent Leave and Earning Statement (LES). The question might meet your personal needs but does little to help resolve the patient’s situation.

Restate the patient’s words

Sometimes restatement can be used as a questioning technique. The simple repetition of one or several words from the patient’s last statement can serve as effective questioning. As stated earlier, these skills are interrelated and restatement is also used as attentive behavior to encourage the patient to continue talking. For example, if a patient says, “I feel like no one cares,” the interviewer can respond with, “No one cares?” This interchange would signal to the patient to continue and clarify. Restatement communicates to the patient that the interviewer is listening to every word.

Interview process skills

Interview process skills are those which elicit relevant data, and provide the structure and framework for the interview. Appropriate use of these skills allows the patient to tell the story, and enables the interview to flow smoothly from introduction to termination.

Clarification

This skill requires the patient to elaborate on a vague, ambiguous, or implied statement. To do this, use questions such as, “Are you saying...,” or “Do you mean this...” Clarifications are also used to make a patient’s statement clear and confirm the accuracy of the interviewer’s perceptions about what is being said. If clarification is not used, then inaccurate information may not be corrected and wrong assumptions may remain untested. Clarifications are also very helpful in preventing second-guessing and miscommunication. In fact, the interviewer should clarify what is being said any time there is doubt. Clarification of feeling is a verbal check to ensure understanding of the patient’s feelings. It’s done by gathering more specific information about the feelings exhibited during the interview.

Paraphrase

A paraphrase is a rephrasing of the patient’s significant words and thoughts. Paraphrasing involves selective attention given to the cognitive parts of the patient’s message that are translated in the interviewer’s own words. A good paraphrase indicates active listening because the interviewer is not simply parroting back words. Paraphrasing can also help patients expand or clarify their ideas and focus on a particular situation, event, or behavior.

Reflection

Reflection is an empathetic response that tells the patient that the interviewer is not only listening but also understands the content of what is being said. A reflection is similar to a paraphrase but different in that a reflection adds an emotional tone to the message. Reflection of feeling is a form of behavioral observation in which the interviewer comments on how it appears a person is feeling. Use of this technique accomplishes the following in an interview:

- Focuses attention on current feelings.
- Encourages the patient to talk.
- Provides feedback to the patient on how the interviewer sees the situation affecting the patient emotionally.

Transition

The use of transitions allows the interviewer to move from one subject to another by building a “bridge” from the present topic to the next. This process skill conveys the idea that enough information has been obtained on a particular subject and it’s time to move on. An example of a good transition is, “I have a clear picture of how it was for you growing up in the military. Now, let’s talk about your first job.”

Leading statement

Leading statements are similar to transitions; however, they are used when the interviewer wants to change the direction of questioning. It’s a signal to the patient that the content of the interview is about to change or head in a different direction. An example is, “Sometimes when people feel depressed, one of the first things they notice is a change in their sleeping habits. Have you noticed any change in your sleeping habits?” As you can see, the leading statement is directive, but it allows the patient freedom to respond in any way. Leading statements are great precursors to any type of question because they allow the patient time to think about a response.

Questioning angry patients

Angry patients can be very disarming even for the experienced clinician. All of your skills relating to appropriate patient care will be summoned to deal with someone who is angry.

Not all patients who show up at our clinics do so willingly. Commander-directed evaluations, situations related to substance use, or instances of suspected family violence could cause a military member to be involuntarily sent for mental health services. Naturally, these individuals will not be happy about their current situation. They will display varying levels of anger. Some may be mildly

annoyed, yet cooperative; others will be openly hostile. Anger in almost any case is a challenge. However, at some point, we have to get past the anger and complete the task of conducting the interview.

Recall that empathy is one of the critical characteristics to have to conduct a good interview; dealing with an angry patient is certainly a situation that would call for the use of empathy. Take a moment to imagine how you would feel if you were in your patient's shoes. You've been sent against your will to talk to someone you don't know who has no business poking around in your personal life.

Don't take the anger personally. After all, does the patient really know you well enough to be that angry with you? Here's another good example of a situation in which you must possess self-awareness. Take stock of how you're feeling as you engage the angry patient. Be aware of transference and counter-transference.

Finally, and most importantly, never underestimate the anger of your patient. Your safety and the patient's safety should be at the forefront of your mind at all times. Be familiar with the safety measures of your clinic and don't hesitate to use them should you sense the anger is escalating. Remember, an assaultive patient is a police problem; this is not the time for you to be a hero.

Confronting

Generally, when we think about confrontation, anger and hostility are called to mind. However, when we use confrontation in the context of the therapeutic relationship, it is neither angry nor hostile. When we confront a patient, we are simply bringing him or her face to face with inconsistent information. The benefit is the patient is able to perhaps become more aware of something that he or she has ignored or denied in his or her life. A common error in using confrontation is to present it in a threatening or accusatory manner. This will certainly cause the patient to be defensive.

Self-disclosure

When you provide limited personal information to the patient, you are using self-disclosure. Appropriately used, self-disclosure can be very beneficial to the patient. It communicates to the patient that you have a clear understanding of what he or she is going through because, perhaps, you have been through something similar. Self-disclosure also validates your empathy. For instance, if you're working with a young airman who has left home for the first time, you might display empathy by simply stating: "It sounds to me like you're feeling pretty homesick." Here, self-disclosure might be very beneficial: "I remember how difficult it was when I left home for the first time and entered the Air Force." There *is* a limit to self-disclosure though.

Disclosing too much is a common error in the use of this technique. Interviewers make this error when they disclose information related to unresolved issues or when they disclose too much. When this happens, the focus of the interview often shifts from the needs of the patient to the needs of the interviewer. Using the example above, you would not want to continue discussing your homesickness as an airman by following up with, "I still struggle to this day with homesickness... there are days when I wonder when I'll be able to see my relatives again and feel like giving up!"

Before using self-disclosure, it is important to understand your reasons for disclosing. Will the patient benefit from having this information? Or, perhaps it is meeting a need of your own. Clearly, using self-disclosure is a delicate balancing act between working for the good of your patient and unethical behavior.

Silence

A controlled silence is designed to stimulate a response from the patient. Many novice or inexperienced journeymen are uncomfortable with silence in an interview. The interview can be exhausting not only for the patient but for you the interviewer as well. A periodic moment of silence allows you to focus on the direction of the interview and the patient an opportunity to break. The silence should not be a prolonged silence, but enough to regain your momentum. Silence is also likely

to increase the patient's participation in the interview and allows the patient to tell the story. Silence can also be used to allow the patient to think, cry, or just sit in a non-threatening environment where it is made clear that not every moment must be filled with talk.

Direction and control

The interviewer maintains direction and control by managing the time, remaining task oriented, ensuring all phases are covered, and using transitions to move from one area to the next.

Know your boundaries

Recognizing what your boundaries are and not over-stepping them is a sign of competence and self-awareness. If you feel you're "in over your head," you probably are. The responsibility to your patient includes the responsibility to refer him or her to an area of expertise or a more experienced staff member when appropriate.

Summary

A summary is a review by the interviewer of what was said in the interview. Summaries should be spaced out during the interview with at least two in the first 20 minutes of the interview, one in the middle, and a final summary to close out the interview. They should be relatively concise but not verbatim; simply a series of statements relevant to the patient's situation. Summaries show the patient that you are paying close attention to what is being said, and they help you to remember information that is passed on in the interview.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

401. Improving interviewing skills

1. What effect does the lack of self-awareness by a journeyman have on a patient?
2. Define empathy.
3. When establishing a therapeutic alliance initially, how will the patient view the interviewer?
4. Why is it important for the patient to view the interviewer as an ally instead of a person who is in a position of authority? Give two reasons.
5. What interviewing skills are considered critical?

402. Interviewing principles and techniques

1. What is verbal following?
2. What words are considered most effective when using open-ended questions?
3. What words are often associated with close-ended questions?
4. What are the benefits of using reflection in an interview?
5. What is the benefit of self-disclosure to a patient in an interview?

1-2. Historical and Collateral Resources

In regards to performing assessments, not all patients who enter Mental Health Services will be good historians. There are a variety of reasons for this lapse; some are for manipulative reasons while others are the result of real cognitive dysfunctions. Determining what brought your patient to the clinic is an excellent beginning. Has the patient been directed to the clinic for a commander-directed or a substance abuse evaluation? Does the patient have an “agenda” or anticipated outcome as it relates to the visit? If so, he or she is much more likely to manipulate historical events to his or her benefit. If the patient is self-referred and actively seeking resolution to a problem in his or her life, he or she is more likely to relay an accurate historical depiction of his or her life. Again, knowing why the patient is at your clinic is a launching point.

You will have several options to collect collateral information that can be used to compliment or contradict your interview with a patient. Your first step is to identify what collateral information you have at your disposal. This is primarily determined by how your patient arrived in your office, primarily was the patient self-referred or commander-directed? You should rely primarily on your interviewing skills to solicit information from the patient and other resources as an alternative. This lesson will identify those resources you have access to and under what conditions you may use them.

403. Resources for self-referred patients

The patient who is self-referred or referred for a medical consultation will generally be cooperative and readily relay historical information regarding his or her past psychiatric history. While some patients arrive as self-referred, it may be masked in the fact that their spouse or supervisor is highly recommending they seek assistance. Differentiating can be helpful in gauging the level of resistance as well. Your basic interviewing techniques learned in technical training will be paramount in knowing what information is relevant. Listed below are a few common resources that are often easily accessible for the self-referred patient.

Outpatient medical records

If you are interviewing a self-referred patient, you automatically have a “need to know” to access the individual’s medical records. The patient’s permission is not needed. Reviewing the outpatient records (OPR) should be a matter of practice as it relates to a patient assessment and is an excellent

beginning. A review of the OPR will allow you to become familiar with any previous psychiatric treatment, chronic medical conditions, or injuries that may be related to the patient's visit. Review and note any medications the patient may be taking. Recent or current medication usage can contribute to or mask the patient's present complaint.

Mental Health and Family Advocacy Program records

This is another instance where you automatically have a "need to know" if you are preparing to interview a self-referred patient to access these records. The records should be readily accessible in your clinic or in the Family Advocacy Program's (FAP) office. If records of a previous visit are available, you will be able to quickly note previous treatment or FAP involvement that may be relevant to this visit.

Family

The patient's family members are often the best historians for a patient. The transient nature of the military makes it unlikely that others will know much about the patient historically beyond a couple of years. If the patient is self-referred, cooperative, cognizant, and a good historian you should avoid seeking family involvement. Remember, you cannot contact the patient's family unless the patient has authorized you to do so via a signed *Release of Information*. Doing so will violate the patient's confidentiality or right to privacy. Remember, serious legal consequences can result from failing to protect a patient's privacy.

Command, supervisor, peers

Who knows your patient as well as his or her family? What about coworkers, supervisor, or commander? Again, if the patient is self-referred you must request a *Release of Information* prior to talking to anyone in his command to seek collateral data. The same rules apply as when seeking input from the patient's family. If the patient is self-referred, cooperative, cognizant, and a good historian you should avoid seeking collateral input from the command, supervisor, or peers.

There are instances when a patient's commander or first sergeant will need to be contacted without the permission of the patient. These include suicidal and homicidal ideation, threats, or gestures; threats to national security; or inability to perform Personnel Reliability Program (PRP) responsibilities IAW ***DOD Regulation 5210.42***, *Nuclear Weapons Personnel Reliability Program*. For specific guidance please review the aforementioned regulation.

Personnel records

Personnel records are generally not available unless the self-referred patient provides them. The benefit of having them would be to compare the patient's performance and behavioral history as it relates to the reason they are seeking treatment.

404. Resources for non-voluntary referrals

Involuntary referrals are usually less cooperative and forthcoming with any personal information about themselves. Non-voluntary referrals usually believe they do not belong in the clinic or they see the referral as punishment. In either case you may be forced to contact and collect collateral information from numerous sources. Knowing where the resources are located and who you can talk with without obtaining a *Release of Information* can make the process much less cumbersome.

Some examples of involuntary referrals include Commander-Directed Evaluations (CDE). Review AFI 44-109, *Mental Health and Military Law*, to become familiar with all aspects of the CDE process. An allegation of family maltreatment will result in a commander-directed referral to the FAP for an evaluation. Again, AFI 40-301, *Family Advocacy*, provides guidance on responding to an allegation or incident of family maltreatment. Any substance abuse incident will generally initiate a mandatory referral to the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program.

Outpatient records

Your access to the OPR remains the same as it was under the self-referred patient. You can access the record on a need-to-know basis only. Do not abuse this privilege. Unlike a self-referred patient OPR review, your attention in a non-voluntary review may be directed towards areas which are similar to the referral, i.e. past CDEs or FAP involvement.

Mental Health and FAP records

Again, access to these records remains the same as the self-referred patient with the focus being on a history similar to the non-voluntary review.

Family

There are instances where you can contact a patient's family and others where it remains a breach of privacy. A CDE doesn't give clinic personnel the right to contact the commander-directed individual's family. However, a referral for FAP or ADAPT encourages family involvement. Family members' input is essential in these instances as long as it is not contaminated by the referred member prior to your contact with the family members. Family members may not always be cooperative or willing to help despite sometimes being victims of abuse themselves for fear of reprisal by the alleged offender, fear of getting the referred member in trouble, or fear of losing their livelihood if the sponsor is prosecuted or removed from the military.

Personnel records

Non-voluntary referrals are often accompanied by supporting information from the patient's personnel files. Past Enlisted Performance Reports (EPR) or Officer Performance Reports (OPR), previous Letters of Counseling (LOC), Letters of Reprimand (LOR), Letters of Admonishment (LOA), Article 15s, or civilian legal problems provide a historical baseline for past conduct. If these items are not initially made available, you can request them from the commander or first sergeant as it would be a vital piece of information to consider in an evaluation.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

403. Resources for self-referred patients

1. How do some patients mask their status as a self-referral?
2. What information can be gained by reviewing the patient's Outpatient Record?
3. When should you avoid soliciting information from a self-referred patient's family?
4. What are some instances when a self-referred patient's commander or first sergeant can be contacted without the consent of the patient?

404. Resources for non-voluntary referrals

1. What are some examples of patients who report to the clinic as non-voluntary referrals?
2. Why might family members be uncooperative as a resource of the non-voluntary referral?

1-3. Explore Social and Substance Use History

Exploring a patient's social and substance use history will require you to focus on specific elements which we will cover in this section. It is within the confines of the social and, if necessary, substance use history where you begin to develop an understanding of the bio-psychosocial aspects of a patient's life. As you studied the developmental characteristics earlier in your career development courses (CDC), most events in a patient's life emerge through a sequence of events. While some events in our lives are unexpected and traumatic, others are emerging slowly over time. You will be required to solicit key information from a patient during an intake interview. This section will identify those key areas.

405. Identifying key elements of the social history

As a Mental Health Journeyman your ability to establish rapport with a patient is never more important than when asking very personal questions regarding a patient's life or lifestyle. Asking relevant questions during an initial assessment will help clarify and create a sense of purpose to your interview. Do not be afraid to ask questions for clarification. Do not assume you know what the patient means. If you are unsure, ask. This does two things: clarifies any questions you may have and tells the patient that you are engaged and listening to what he or she is saying. Maturity is a must. Your ability to ask difficult questions is paramount to patient care. This requires maturity and a level of self-awareness, which is exhibited in your confidence and competence.

The social history consists of three key areas—social, occupational/academic, and home environment. As a novice, the journeyman tends to attempt to address each area with equal time constraints and detail. You will soon discover that while all of these areas need to be addressed, time spent on any one area is often dictated by what brought the patient to the clinic. For instance, if a patient is experiencing occupational problems, you may want to spend additional time exploring this area as a focus for future treatment. Let's begin by looking at each of the key areas.

Social

The focus of this key area is on a patient's social life. Key factors to consider in this area include relationships, marriage, children, and sexuality.

Relationships

Begin by identifying those relationships the patient feels are significant in their lives. Many of our relationships are formed or centered on our parents, siblings, peers, and coworkers. Examine the patient's relationships in developmental milestones. How do they relate to others? Did they engage in romantic relationships as an adolescent? Is the patient isolated or do they have a circle of friends or peers with whom they are able to socialize? Do they have a "best friend"? What is the length of time they have had friends. This can be diagnostically significant if the patient is unable to maintain a meaningful relationship with others for a significant period of time. Are they intentionally isolated? How do they relate to others in the world around them? Technological advances have brought untold ease to many of our lives. Some people have used this venue to further isolate themselves from the outside world. When patients are describing relationships, explore whether the relationship is one in

the traditional sense of face-to-face communication or if it is a virtual relationship based upon interaction on a computer screen. Increasingly, this is often a patient's only form of interaction.

Marriage

What is the patient's marital status? You will basically be inquiring about a patient's marital history. For example are there multiple marriages? At what age was the patient first married? Is he or she a widow, widower, divorced, never married, etc? Also explore relationships which have emulated marriage. For instance, has the patient been involved in "common law" marriages/relationships or cohabitation that ended failed? Is there a pattern of moving from one relationship to another?

This area includes some suggested questions that may be appropriate to ask you patient. Remember, every patient is unique and asking relevant questions based upon his or her presentation is important as well.

Children

Does the patient have any children? Explore the relationship the patient has with biological, step or foster children. Is the patient involved or estranged from the children. If the patient is the non-custodial parent of a child, what is his or her level of involvement with his or her child(ren)? How often does he or she see his or her child or children?

Are any of their children deceased? If so, what were the circumstances surrounding the child's death?

Sexuality

Common questions you may likely pose as a Mental Health Journeyman as it relates to sexuality would include exploring events surrounding past or current sexual abuse, or sexual dysfunctions as it relates to the patient's chief complaint. Is this often an uncomfortable and awkward subject for the journeyman? Sure it is. If you consider the clinical importance when you ask the question and treat it professionally, then the question will make sense. If you act professional, the client will most likely consider it a professional question. He or she may even be anticipating a question about his or her sexual history. When you go to the doctor and the doctor needs to examine you, you are sometimes told to disrobe and to put on a flimsy hospital gown. When the technician asks you to get undressed, hopefully he or she is matter-of-fact about it. Now, imagine the same scenario with a technician holding the hospital gown while glaring at you and saying in a creepy voice, "Go ahead and put this on." The professionalism you put into asking the question will help put the client at ease. Focus on the necessity of the information you are asking and not merely out of curiosity. The latter will get you in serious trouble.

Has the patient's own sexual conduct ever caused him or her legal, personal, or relationship problems? Maturity of the journeyman in exploring these areas is paramount. Exploring these areas should center on the patient's chief complaint.

Occupational/academic/financial

The focus in this key area of a patient's history includes the academic, occupational, and financial aspects of his or her life.

Academic

Knowing your patient's educational level allows you to better communicate and suggest treatment options for the patient. Did the patient graduate from high school, trade school, college etc.? Did he or she have difficulties in military technical training school?

Lack of pursuing higher academic functioning should not be construed as a lack of mental functioning. The patient's educational level will be important as it relates to conducting psychometric examinations, assigning homework, or participation in group activities. Explore this area in depth to gain a complete grasp of your patient's capabilities.

Occupation history

Identify the length and performance of your patient's past occupational history. If the patient is active-duty, inquire about both pre- and post-military performance. What has the patient's performance reports reflected concerning past performance or behavior? What is his or her level of responsibility or highest rank held?

If the patient is non-military, inquire about the length of his or her employment and past employment. Why did he or she leave or were he or she let go by his or her previous employer?

Financial status

Describe the financial status of your patient. Is the patient financially stable or is he or she struggling? Does the patient receive financial assistance from the state or others to meet his or her financial obligations? Are there any legal problems resulting from financial mismanagement or unexpected devastating events (fire, tornado, flood, etc.)?

Home environment

The focus in this key area of a patient's history includes the support network, legal history, domestic violence history, religious history, and values.

Support network, living arrangements

Identify who the patient considers to be in his or her support network. Also, ask the patient to describe his or her living arrangements. Is the patient in the dorm, living with friends, or his or her family, etc.?

Additional social history

The following areas may be very significant or not at all based upon the patient's chief complaint.

Legal history

Identify all past or current legal problems to include court-martials, civilian court convictions, arrests, or pending legal action.

Domestic violence

Note any involvement with FAP or civilian Department of Human Services as the result of domestic violence.

Religion

Does your patient believe in a higher power? What are the patient's beliefs?

Values

Can your patient articulate his or her values based upon personal conviction?

406. Exploring a client's substance use history

Knowing your patient's substance use history and the progression of his or her usage will prove essential later when you begin treatment planning. The following information will provide you with some very specific, targeted questions you can use as you explore the patient's substance use history. Keep in mind, the patient may not always be forthcoming during this interview. You should always review the resources you have at your disposal prior to the interview, particularly if substance use will be the focus, so you will be prepared to further assist the patient as necessary.

There are many different questionnaires, mnemonics, and assessment tools to assist you in determining the extent of a patient's substance use. Nothing can really replace the face-to-face interview. This lesson will stick to the basics of good old-fashioned sleuthing to gather patient data.

Exploring substance use history

When exploring a substance use history, you will want to focus on a few main topics to include: substances used, frequency of use, progression of use, severity of use, onset, the primary substance used, how they use, and the effects of the client's use.

Substances used

Use this area to begin identifying and chronologically organizing the patient's substance use. However uneventful or inconsequential the patient may feel the use was at the time, it should be documented. Document all experimental and one-time usage, over-the-counter (OTC) medication abuse or misuse as well. Poly substance use/abuse indications and contraindications should be explored as well.

Frequency

Identify how often the patient is/was using a substance. Is he or she using daily, weekly, binge drinking, etc.?

Progression

Taking what the patient revealed regarding his or her use history and pairing it with progression is important. Knowing how the patient's drinking has progressed will give you an idea of increased tolerance and/or a progression to a more powerful substance. Ask what the patient's tolerance level is or the amount needed to achieve intoxication. Have there been attempts to quit using the substance? How many times has he or she attempted to quit and what was the outcome?

Severity/amount used

Now that the patient knows how much of a substance it takes to achieve intoxication, how much does he or she often use? Simply knowing how much a patient needs to use doesn't mean that is all he or she uses. Patients will often use well beyond achieving intoxication.

Identify any adverse consequences that have occurred from their usage.

Onset

From the historical data already gathered, identify when the patient feels his or her substance use/abuse may have increased to regular usage.

Primary substance

Identify the user's drug of choice. Even if the patient is a poly substance abuser, one substance will typically stand out as his or her preferred drug of choice.

Route of administration

Identify how the substance is introduced to the user's body, i.e., oral, anal, inhalant, snorting, eating, injecting, popping, drinking, etc.

Effects

Questioning the patient regarding symptoms related to substance abuse or withdrawal resulting from abstinence is not good enough. Many patients may not be able to identify any symptoms. They may feel these symptoms are the natural results of being hung-over or have grown accustomed to experiencing these effects; therefore, they are no longer considered abnormal. Help the patient identify the effects of substance use/abuse by specifically asking if he or she has encountered any abnormal effects such as blackouts, tremors, increased tolerance, physiological symptoms, or medical complications that may be exacerbated by substance usage.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

405. Identifying key elements of the social history

1. Many of our relationships are formed or centered on which individuals?
2. What is the benefit of knowing your patient's educational level?

406. Exploring a client's substance use history

1. In which area of the substance use history would you ask about how often the patient is/was using a substance?
2. What is the benefit of taking what a patient reveals regarding his or her use history and paring it with progression?

1-4. The Mental Status Examination

Completing a thorough MSE is a major portion of the initial *intake interview*. As a Mental Health Journeyman, you must be able to quickly assess and develop an understanding of the patient's mental state and psychological functioning. The ability to quickly assess a patient should be one of your major goals during your clinic experiences. A skillfully recorded MSE will provide a reliable foundation for comparison of current and past behavioral and psychological traits displayed by the patient. This is another tool you can use to provide a systematic observation and evaluation of crucial behaviors and determine a patient's mental state. More importantly, the MSE will provide indicators to you and the provider regarding future treatment choices.

407. Data gathering guidelines and procedures

The primary purpose for conducting a MSE is to gather objective data which may be helpful in determining etiology (cause), diagnosis, treatment, and prognosis (outcome). The goal of the MSE is to assess quantitatively and qualitatively a range of mental functions at a specific time. When observed objectively and documented appropriately this data will provide a solid baseline for future evaluations. It differs from a patient history in that it is used to assess and document a patient's present mental state and, unlike a history, does not remain stable. The MSE assesses a variety of basic observational and cognitive behaviors to include patient's orientation, appearance, emotions, cognitive functioning, thought patterns, and speech, although not necessarily in that order. The examination provides a foundation for psychiatric diagnosis and clinical assessment. The MSE is not used by itself to diagnose a patient. All of the information gathered during an intake interview is combined, assessed, and interpreted properly to get a truly accurate picture of the patient and his or her needs.

The majority of MSE assessment information is gathered during the initial interview. The information you record as a result of the interview will be the basis of many decisions regarding the patient's future treatment; therefore, it *must be accurate*. To be accurate, it must be recorded properly in the case files. Every detail you can put in your write-up concerning how the patient is presenting himself

or herself on that first visit is crucial. Imagine if you were not around when the patient came in for a follow-up appointment. If you don't have a good picture of the client presented in your write-up, the rest of the staff may not know how different the client is presenting himself or herself during future appointments. Let's look at some general guidelines that will aid you in gathering information.

Listen and observe

You must listen to and observe the patient carefully. Your observations should go unnoticed by the patient and be as seamless as a normal conversation. Most of your observations will occur throughout the course of an interview. You may notice oddities or peculiarities your patient may voice or display during the interview. Your focus should be on specific behavior. If the patient displays abnormal or unusual behavior, you should make a mental note to that effect. Follow-up questioning may be required to help clarify the extent of the patient's deficit in function.

Advise the patient

Always explain the nature and purpose of the interview and the MSE to the patients. Remind the patients that your questions are part of every complete patient evaluation. You can help reduce some of the patients' anxiety by letting them know that some of your questions may be easy to answer and others may be quite difficult. This technique will help keep the patients from being offended by questions that are considered "personal" in nature. Again, imagine you are in their shoes. You are coming to this clinic for help and this person seems to be asking random questions. Tell the client what areas you are going to ask about so he or she will have some sense of what to expect from the appointment. This is the verbal equivalent of telling a patient what is about to happen before you take his or her blood pressure with a blood pressure cuff. The procedure of advising patients is mandated at most military medical facilities. As with any procedure in a treatment facility, you want to be aware of what is about to take place; our job is no different in that manner.

Maintain awareness

You should always be aware of the privileged nature of your relationship with the patient and of the information you are receiving in response to your questions. You are required to maintain confidentiality with regard to any information gathered during an assessment. Some of your questions may embarrass the patient or on the flip side, you may be embarrassed by the response the patient gives. Experience and exposure to multiple interviews and situations will help ease your uneasiness.

You need to be able to note subtle behavioral changes in a patient's responses. Such things as a change in voice pitch, change in eye contact, tears, heavy sighs, overt swallowing or other physical responses, and hesitancy to answer particular questions, may all be indicators that you have touched on an area of importance to the patient. Further questions in areas eliciting these responses may reveal helpful information regarding the patient's thought processes or basis for unusual or abnormal response. Try not to stray away from the material that must be covered to complete the examination during your questioning in a particular area. You should have a structured plan for covering all aspects of the MSE. We will discuss areas that should be covered in the MSE later in this unit.

Clarify the problem

Certain complaints, signs, or symptoms require further questioning to clarify the severity and nature of the problem. For example, if a patient reveals that he or she is experiencing hallucinations; questions should be asked to clarify the type, content, response, and time and place of occurrence. Most importantly, it is essential for you to detail the patient's responses regarding the hallucinations. Questions that should be answered are:

1. Are the hallucinations auditory, olfactory (smell), visual, tactile, or gustatory (taste)?
2. Are they disturbing or comforting?
3. Do they occur in only one part of the visual field?
4. Do they command the patient to do certain acts (harmful or helpful)?

5. Do they seem to stem from one particular source or are there many aspects to their origination and direction?

As you can see, you must know what follow-up questions are appropriate based upon what the patient presents. Hallucinations are used in the example above; however, any topic or presentation the patient exhibits or reveals that needs clarification should be pursued. If you, as the technician, do not understand what the patient is saying or doing, it will be impossible for another paraprofessional or provider to review your write-up and comprehend what you did or did not articulate from the interview.

Documentation

All of the interviewing and careful observations will be for nothing if you do not document what you have observed. Documentation in this area is vitally important and must be accurate. Subjectivity should be very limited in the MSE. Always document exactly what you observe.

Let's briefly look at some examples where clarification should be used. "SSgt Goins appeared mad" was used to describe a patient's mood in an intake interview. What does that mean? The word "appeared" in a write-up gives the impression you are unsure of what you observed, "It looked like, but I'm not sure." Avoid using the word "appeared" in your write-ups unless it is accompanied by "as evidenced by." The example above could be clarified by stating "SSgt Goins appeared mad, as evidenced by his clenched fists, loud speech, and his stating he was angry." This clarifies to everyone what you observed, otherwise the reader is left to imagine or visualize what SSgt Goins may have appeared like at that moment.

When you use statements in a "matter-of-fact" manner, it eliminates embellishment and personal emotions that are often inserted into an observation. Another word of caution when documenting the MSE is to avoid personal jargon or slang to describe patient's actions. "He was madder than a", "She was running around like a....." This is unprofessional and lacks any substance in accurately depicting a patient's condition.

Knowing how to conduct an MSE is only half of the task, documenting your observations completes the task. It is vitally important you are able to articulate your observations in a professional manner.

408. Content of a mental status examination

There are many different design formats used to accomplish the mental status examination. In most cases, however, specific areas of assessment must be addressed. The *primary* assessment areas of the MSE we will look at are listed below:

- Appearance and behavior.
- Emotions.
- Cognitive functioning.

These general headings contain many sub-areas or headings which combine to present an overall picture of a patient's condition. Some of the other MSE formats contain similar headings. Just remember, the MSE, in whatever form, must reference the above areas to present a concise evaluative tool. The other formats simply differ in design rather than content.

Appearance and behavior

In this area, it is important to note how the patient looks on initial contact. This is your first impression or observation of the patient. You should record clothing, personal hygiene, excessive use of cosmetics or faddish garments, posture, poise, and other elements relevant to the patient's outward appearance. Additionally, note whether the patient looks sickly, robust, tired, or shows overt signs of a specific disorder; again, with examples to support your assertion. Alcoholism, for example, may be manifested by facial flushing, spider angiomas, or palmer erythema (extreme redness on the palms of

the hands). Look for items that suggest behavioral characteristics such as the ones listed in the following table.

Behavior Traits		
Restlessness	Rigid	Tense
Nail biting	Slumped	Hand wringing
Stereotyped behavior	Agitated	Echopraxia (copying the examiner)
Licking of lips	Gestures	Twitches

Does the patient avoid eye contact with the interviewer, remain in an unnatural position, possess the ability to write, nod yes or no? Does he or she remain mute to the questions? These are only a sample of appearance and behavior factors that you may witness upon initial contact with a patient. Record these details carefully enough so that a third party could identify the individual from your description without ever having seen the patient.

Emotions

In this area, you will be focusing on the patient's mood and affect. Mood is defined as the internal emotional tone. Affect is simply the *observable* external expression of the patient's internal emotional tone. Let's briefly discuss mood and affect.

Mood

Again, to define mood, it is the internal emotional tone. Sometimes mood is masked by the outward observable behavior called affect which we will review in the next section. Is the patient happy or sad? Are there indications of depression such as difficulty sleeping, appetite problems, social withdrawal, weight gain or loss, or loss of libido? If the patient is depressed, the chances are good that he or she views other people and perhaps the entire world as worthless and may respond according to that perception. Mood is important to evaluate because inappropriate mood is often a sign of emotional illness. The elated individual who responds with increased happiness to almost every contact or endeavor is a good example. Is the elation appropriate or inappropriate? Does the patient respond to matter-of-fact questioning with laughter or jocularity instead of a common-sense or well thought out response?

It is important to recognize the degree to which a patient is depressed or elated. Additionally, it is important to evaluate mood because *extended* periods of depression or elation may indicate a specific type of illness.

Affect

A patient's affect should closely parallel or show congruency with his or her mood. This is the observable portion of mood and should complement the patient's mood. A lack of congruency between mood and affect can be an indicator of a more serious psychological problem.

The behavior of the patient should indicate what type of mood is prevalent. Affect has three major components that have tangible expression:

1. Facial expression.
2. Gestures.
3. Speech.

Facial expression and gestures are readily observable, while speech requires that you pay closer attention to what the patient is saying and how he or she is saying it. You should note the flow, volume, pressure, rhythm, and tone of the patient's speech. Speech is the best observable gauge of the internal thought process.

Primary Types of Affect	
Appropriate	When the patient expresses feelings consistent with the content of speech and mood, the patient's affect is said to be appropriate.
Inappropriate	Does the patient's affect correlate with what is being discussed? Does the patient laugh while speaking of a death in the family? If so, this would be an example of inappropriate affect.
Flat	Flat affect usually refers to a patient who shows very little emotion. The primary sign of an individual displaying flat affect is a marked noted absence of feeling or response.
Blunted	Blunted affect refers to the patient who is grossly diminished in his or her range of emotions. There are small amounts of emotion displayed which normally are inadequate as related to the stimuli provided.
Labile	Labile affect is seen as unstable, sudden changes in a patient's response. An example would be a patient who is crying one minute and laughing the next.

All types of affect are important to note, especially inappropriate, flat, or labile. Disorders of effective expression of emotions (lack of ability to express feelings) are often a sign of serious problems.

Cognitive functioning

This area is the largest section of the mental status examination. Cognitive simply means mental awareness or fully informed. When we speak of cognitive functioning in a patient, we are evaluating an area which focuses on the patient's mental processes of perception, reasoning, intuition, knowledge, and learning ability. Cognitive awareness is a compilation of these processes by patients in determining the current status of their surroundings and situation.

When do we assess cognitive functioning? Some professionals believe it should be tested at the onset of the MSE, while others believe it should be tested upon conclusion of the examination. A third viewpoint says cognitive assessment is best performed immediately following observation of the patient's initial presentation, motor behavior, and affect—before an attempt is made at assessing thought and mood. The reason for this approach is that impairment of cognitive functioning may be mistaken as a mood disturbance or thought disorder. The areas of cognitive functioning that need to be addressed are:

- Orientation.
- Memory.
- Attention/concentration.
- Thought process.
- Thought content.
- Intelligence.
- Insight.
- Judgment.
- Perceptual processes.
- Suicide ideation or intent.

Orientation

Orientation is addressed with reference to the person, place, time, and situation. Do patients know who they are, where they are, the day of the week, the month of the year, and the particular situation in which they find themselves? Orientation to person (who they are) is over learned information which is seldom forgotten. Failure to give one's name may occur in hysterical dissociation and reflects possible negativism, confusion, distraction, hearing impairment, or language barrier or disorder. Even in cases of organic brain disease, the name is seldom forgotten.

Memory

Memory assessment is traditionally expressed as three types: immediate recall, recent memory, and remote memory. Other areas of assessment are visual memory and recent past memory.

Immediate recall

This represents the patient's ability to remember that which has immediately gone before. Does he or she repeat previously quoted material during the interview? Does the patient ask for help regarding what has just been verbalized, e.g., "Did I mention that already?" Can the patient recall your recent comments? Immediate recall can be tested by asking the patient to repeat a name, address or to name a set of objects, for example, car, horse, house, and telephone. The patient should be asked to repeat these items again after several minutes have passed. Gradually lengthening this list will provide you with an awareness of the degree of immediate recall function or impairment.

Recent memory

This indicates the patient's ability to recall events of the past minutes or days. Orientation to place and time also reflects recent memory. Asking the patient to learn new information is valuable in this assessment. This is commonly done by asking the patient to remember three or four words and advising the patient that he or she will be asked to recall them later in the examination. After approximately five minutes, ask the patient to recall the three or four words you relayed.

If the patient has difficulty learning the three or four words mentioned earlier, it may indicate an attention deficit problem. If you fail to determine that the patient can immediately repeat the words you wish recalled, any conclusions of recent memory functioning as related to that particular tasking may be invalid.

Remote memory

This is the patient's ability to recall events of weeks or years ago. This type is difficult to assess since the examiner may not know enough about the patient's history to ask pertinent or verifiable questions. Questions like, "Can you tell me where you attended grade school?" or "Do you remember where you lived as a child?" help to establish remote memory function indicators. However, the patient's responses may not be verifiable by you immediately. Questions relating to the patient's military history might provide more information regarding remote memory functioning because you can verify patient responses by reviewing the personnel or medical records of the patient. Past hospitalizations early in the patient's career can be verified almost immediately.

Reviewing patient records can provide you with material for questions and answers. Questions relating to past presidents, dates and places of wars, and events that affect everyone can prove extremely beneficial to your assessment.

Attention/concentration

Many things impair a patient's ability to concentrate. Many of you have had difficulty concentrating from time to time. Anxiety, depression, or in severe cases auditory hallucinations may all contribute to impaired patient concentration. Note whether obvious anxiety, depression, or other factors are present with regards to the attention/concentration span of the patient.

One of the most basic tests in evaluating the attention/concentration span of a patient is serial 7 subtractions. Subtracting serial 7s is a task requiring intact cognitive capacity and concentration. This test is given by asking the patient to subtract 7s from 100 and to continue subtracting. If the patient cannot subtract 7s, try 3s. If the patient cannot accomplish this, the task should be discontinued and documented. This is essential information that could indicate a learning deficit, organic brain disease, or one of the other areas previously mentioned. Also indicate how far the patient progresses in the subtraction process. The ability for the patient to concentrate for an extended period is commonly referred to as "vigilance." Anxiety, depression, and schizophrenia may impair vigilance without disrupting digital repetition.

Thought process

This area relates to the general form or direction a patient's thinking process is indicating. It is the patient's ability to interpret and mentally organize the flow of conversation or events occurring around them. It can be determined mostly by the manner in which the patient responds verbally. There may be rapid thinking displayed, which progresses to a flight of ideas. Thought blocking should be noted. This impairment is characterized by sudden cessation of thought or speech, and often occurs in schizophrenia and sometimes to a lesser degree in patients suffering anxiety.

Thought process can be described as concrete, tangential (inability to remain focused on the subject being discussed), circumstantial (digressive but able to return to the primary subject), persevering (sticking to one thought or idea), loose (absence of logical progression), or incoherent.

Thought content

This area concerns the nature of particular ideas being expressed by the patient. Are the thoughts expressed considered odd or peculiar? Does the patient indicate thoughts of doing harm to him or herself or to others? Are there any prevalent delusions being communicated such as "I talked to God today and He said I could sit by His side." Other delusions may be bizarre and indicate thoughts of external control factors over the patient's thinking.

A patient may state a belief that thoughts are inserted into, and withdrawn from, his or her head while asleep. You should be careful to note any preoccupations, ambitions, phobias, and perceptual disturbances such as illusions or hallucinations.

When a patient communicates specific fears, listen carefully and explore the origins of their fears. A statement such as, "I don't want to go out to eat anymore," may have several different meanings. Patients suffering from major depression may feel too tired to exert the energy to go out or may have lost all interest in socializing for pleasure. Exploring all statements that have no finality to their meaning allows a more thorough understanding of the true factors affecting the patient's thought content.

Intelligence

An overall estimate of general intelligence, which places the patient in either the above average, average, or the below average area, is usually sufficient for this assessment. Indicators for judging the intelligence of the patient are the extent and usage of vocabulary, range of general knowledge, reasoning powers, and level of maturity displayed.

Mathematics can be used to assist in the assessment. Asking the patient to tell you how much change is due from a \$20 bill after purchasing something for \$8.43 will help in determining not only intelligence, but possible organic impairment affecting intelligence response. Fund of knowledge may be assessed by asking questions about such things as art, politics, history, geography, and literature. These questions also help assess recent and remote memory. Planning your assessment to include this type of questioning prevents you from displaying a "scheduled approach" appearance to the patient. Intelligence is normally displayed in a wide variety of interests by the patient; however, individuals with superior intelligence often have very restricted interests. When a person has a well-developed vocabulary and uses it properly, that's normally a high correlation with intelligence.

Making judgments regarding an individual's intelligence should also include considering socioeconomic and cultural variables. Your judgment, for example, that a patient is of below average intelligence because of an unusual vocabulary would be seen as bias or prejudice—most likely due to your misunderstanding of the language or vocabulary being used. Your judgment is valuable in selecting a course of treatment for the patient. If a health care provider feels the patient cannot tolerate a course of treatment based on your errant findings, the patient's treatment suffers. Subsequently, additional time and money will need to be invested for completion of the treatment process.

Insight

A patient's degree of understanding and capacity to understand what is causing his or her distress or illness are measures of insight. If the patient understands both the problem and the cause, chances are that there is relatively sound, insightful functioning. Can the patient attribute a comprehensible time line to his or her current difficulties? Does he or she blame everyone else for their difficulties or do they accept responsibility? Asking the patient questions such as, "What is your problem as you understand it?" or "What has been helpful in the past for dealing with your problem?" can be helpful in determining a patient's insight. Some patients acquire insight only after behavioral changes have taken place. It is always important to observe cognitive, perceptual, or informational reasons for poor insight. More importantly, note these observations.

Judgment

This area assesses a patient's ability to think and respond appropriately to a problem. The process of sound judgment incorporates consideration and selection of alternatives that are most reasonable and responsive to a problem. One of the best indicators of a patient's judgment is the past decisions he or she has made in dealing with situations and problems of everyday life.

Testing for judgment may be done by asking screening and/or metric questions. An example of a screening question is, "What would you do if you were in a distant airport with only one dollar in your pocket?" An acceptable answer might be to call a friend and ask for money to be wired or go to the nearest traveler's aid function. An unacceptable answer would be hitchhiking home, stowing away, borrowing money from strangers, etc.

Metric questions are a series of specific questions with point values awarded to responses. An example of a metric question is, "What would you do if you woke up at one minute to 7:00 am and remembered that you had an appointment downtown at 7:00 a.m.?" The most sensible response would be to "call the person with whom you have the appointment." This response would be awarded 2 points. Other possible responses and their suggested awarded point values are: "Dress quickly and rush downtown" (1 point); "Cancel the appointment" (1 point since the response is vague); "Go back to bed" (0 points). The last response (go back to bed) obviously shows poor judgment. Impairment in judgment may not necessarily indicate the presence of a mental illness; however, a decline of previous decision-making abilities and the patient's previous judgmental evaluative process could indicate the existence of a problem.

Perceptual processes

Perception refers to the psychological process used to organize and give meaning to various stimuli from the environment. Once the transference of physical stimulation to psychological information is complete, it is said to have been brought to awareness (remember our definition for cognitive functioning earlier in this text). Perception, therefore, can be defined simply as accurate awareness. If the patient displays inaccurate awareness, however, a perceptual disturbance is most likely at fault. Accurate perception is a prerequisite for adaptive behavior, for example, responding appropriately to a stimulus. When accurate awareness is impaired, the patient suffers from behavior seen as inappropriate.

The most common types of perceptual disturbance are hallucinations and illusions. An *illusion* is a misperception or misinterpretation of real external stimuli. A fork next to a lunch plate may be mistakenly interpreted as a snake. *Hallucinations*, of course, are false sensory perceptions not associated with real stimuli. Remember the cultural differences that can sometimes be misinterpreted by the interviewer. Religious beliefs and superstitions are a few of the more common miscues that occur when dealing with patients from other cultures. What you may consider abnormal or unusual thinking is completely normal and plausible to the patient. Be aware of the cultural differences when interviewing a person from a different background than your own.

Suicide ideation or intent

While not listed as a separate entity in most MSE formats, the evaluation of suicidal ideation or discovery of former suicide attempts are critical areas of concern for the patient, technician, and health care provider. You *must* assess suicide during *every* intake interview. Suicide is often an uncomfortable topic for new journeymen to address in an intake interview. It's considered a taboo topic in social settings and rarely do you hear an open discussion regarding suicide. You must address this topic with your patient. Normally, every intake you staff with a provider will end with the provider asking you if the patient expressed any thoughts of suicide. Your intake is not complete and you are doing potentially a grave injustice if you fail to ask.

Remember, it is a myth that you will “plant a seed” suggesting to the patient that suicide may be an option given his or her situation simply because you asked. Many individuals, when faced with extreme diversity, may have the thought of “maybe I can't handle this situation.” Most of us very quickly go the next step of realizing we have support or there are options for the difficult situation. A suicidal person may have trouble seeing any positive options, and you might be the first person to ask him or her the question out loud; “are you thinking of hurting or killing yourself?” If a person lost their spouse and children in a freak accident, there is a strong chance the thought of suicide has crossed his or her mind at some point. You showing your concern about him or her and asking will be seen as a positive thing. He or she more than likely won't say, “Wow, I had never thought of that, but now that you mention it....”

To address a serious health issue in the military the Air Force has created guidance for you and providers to follow. The *Air Force Guide for Managing Suicidal Behavior: Strategies, Resources, and Tools* state the goal of a suicidality evaluation is to assess the risk of a suicidal act reasonably and consistently, in order to guide appropriate intervention, management, and treatment.

Statistically, most military personnel fall into the 20 to 24 young white male population, which also describes the highest population for completed suicides in the Air Force. Females are certainly not left out of the suicide statistics; however, they tend to represent more suicidal gestures with less completed suicides than their male counterparts. This trend unfortunately is changing as females are choosing more lethal forms of suicide such as firearms, resulting in an increase in female completed suicides. With regard to marital status, divorced individuals are most likely to attempt suicide. Military members who are experiencing legal or financial problems are considered more at risk. This is not to say that every patient you encounter with legal or financial problems will attempt to harm himself or herself; however, it's certainly a flag to note and pursue in the interview.

When evaluating an individual whom you feel presents the potential for a suicide attempt, you should maintain a constant awareness of the following:

- Speech and thought content.
- Marked lack of congruency between mood and affect.
- General appearance.
- Agitated or despondent behavior.
- Extreme depression.
- Recent loss of a loved one.
- Confused thinking.
- Hallucinatory episodes.
- Anger or guilt feelings.

This listing, of course, does not cover the entire spectrum. You must stay alert to the possibility of suicidal ideation in any patient that seeks treatment. Any verbalized thought of suicide or suicidal gesture must be viewed as an emergency. *Don't* align set signs or symptoms with certain suicidal risks. Many patients initially seen and diagnosed as manipulative or hysterical have succeeded in self-

destructive acts. If your assessment indicates a risk of suicide, *immediately* determine the severity of the risk. Careful observation, once more, is the key.

Once you have completed the MSE, you must concern yourself with intervention. It is important that you confront the issue of suicide directly. You should inquire about the specific plans the patient has for committing the suicidal act. The more specific the plan is, the higher the risk for suicide. If a client tells you he or she wishes he or she were dead and you inquire on how he or she would do it and he or she says “I don’t really have a plan” it is still important, but it might just be his or her first cry for help. A client who responds by saying “I would shoot myself with my gun that I have in my closet, and I would wait until my spouse and children were out of the house on the weekend so they wouldn’t find me” would be typically seen as a more serious threat. Most importantly, *report* all incidents immediately and then don’t forget to document as many details as possible in the client’s record.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

407. Data gathering guidelines and procedures

1. What is the primary purpose of conducting a MSE?
2. What subtle behavioral changes in a patient’s response may indicate that you have touched on an area of importance to the patient?
3. What does using statements in a matter-of-fact manner accomplish when documenting the MSE?

408. Content of a mental status examination

1. Define the term *mood* as it pertains to a patient’s emotions.
2. Define the term *affect* as it pertains to a patient’s emotions.
3. What does an inappropriate mood often signify?
4. What are the primary types of affect?
5. Define the term *cognitive*.

6. “Can you tell me where you attended school?” would be an example of testing what kind of memory?
7. If a patient cannot accomplish a serial 7 or 3 task, what might this indicate?
8. Describe the term *thought process* as it applies to a patient.
9. What are good measures of insight?
10. What is one of the best indicators of a patient’s judgment?
11. What are the most common types of perceptual disturbance?
12. What is generally true of a patient who has a specific suicide plan?

1-5. Motivational Interviewing

Motivational interviewing (MI) is a method used to help people make changes in their lives. It has been extremely useful in helping patients overcome ambivalence, as well as resistance to change. Although there are a number of techniques used in motivational interviewing, the information presented here will only focus on a general description of the method. Journeyman should not attempt to use this method until they have received formal training.

409. Description of motivational interviewing

MI is a patient-centered, directive method for enhancing intrinsic inspiration to change by exploring and resolving ambivalence. MI is patient-centered—focusing on the concerns, interests, and perspectives of the individual. It is a directive, patient-centered counseling style for eliciting behavioral change by helping patients to explore and resolve ambivalence. The word “interviewing” is used because it doesn’t imply who has more power or is more important in the counseling relationship. It is an INTER-VIEW where the journeyman interacts with the patient in a collaborative, empathic and non-judgmental manner. It is directive by seeking resolution of ambivalence and moving the patient toward positive change.

There are three components to the spirit or underlying philosophy of motivational interviewing—collaboration, evocation, and autonomy.

Collaboration

As addressed earlier in this unit, traditionally, interviewers are viewed as being in the position of power in the therapeutic relationship. MI seeks to level the playing field. Instead of the patient

following the clinician's advice on blind faith, motivational interviewing brings the clinician and the patient together in a joint (collaborative) effort to create change.

Evocation

The root word for evocation is the word evoke. It simply means to summon or to call forth. MI seeks to understand the underlying beliefs, values, or perceptions that influence the behavior of the patient. In essence, we are discovering what motivates the patient. What compels the patient to engage in his or her current behavior? What may compel the patient to change his or her behavior?

Autonomy

MI is an approach that respects the autonomy of the patient. It is based on the premise that change motivated by internal factors is intrinsically more meaningful to the individual than coerced change. It calls on the clinician to respect the patient's right for self-determination, regardless of whether the clinician agrees with the decisions of the patient.

410. Principles of motivational interviewing

The developers of motivational interviewing, Drs. William R. Miller and Stephen Rollnick, assert that four general principles guide the application of motivational interviewing—express empathy, develop discrepancy, roll with resistance, and support self-efficacy. Let's take a look at each of these principles.

Express empathy

As discussed earlier, empathy is the ability to understand the feelings of others. Expressing genuine appropriate empathy is the foundation of all communication. It is void of moral judgments. It's an attitude that allows the patient to be exactly who he or she is and conveys respect. The basic skill for empathy is reflective listening. This technique communicates to the patient that you are listening, understanding, and accepting. This element of motivational interviewing also validates ambivalence and resistance as being a normal part of the human experience. In thinking reflectively, some key questions to ask yourself are: "What do I think the patient means? Why might this be important to the patient? What is the patient feeling? What might the patient be trying to say that isn't being verbalized?" This counseling style is generally one which is quiet and eliciting using reflective statements. This helps patients feel validated, respected, and in control of their own choices.

Develop discrepancy

This area of MI begins to depart from classic patient-centered counseling theory. Eliciting both sides of ambivalence helps a patient see the discrepancy between the problematic behavior that brought the patient to counseling and his or her goals and values (how he or she wants to be). When skillfully done, it changes the patient's perceptions without creating any sense of coercion. The patient must verbalize the reason for change, not the journeyman. The journeyman tailors the development of the discrepancy according to the patient's motivation to change and confidence in his or her ability to successfully make the change. Some patients may have high motivation and low confidence, "I am willing to change, but I can't." While others may have high confidence and low motivation, "I can change if I want, but it isn't important to do so now." Others may have high motivation and high confidence, "I've decided to change and I know what I must do." Again, we use the technique of reflective listening to lead the patient into identifying his or her reasons for making change.

Roll with resistance

In MI, resistance is seen as a counselor skill issue, not a patient's problem. The MI approach accepts that resistance is to be expected. Direct persuasion is not an effective method for resolving ambivalence. If you present an argument, it is quite natural for the other person to argue the opposing view. In MI, the journeyman uses listening skills and reflective statements to elicit the patient to verbalize the reasons to make positive change. Use of analogies, reframing, rulers (1–10 scales) to elicit a patient to give reasons for changing ("change talk") and discussing the good and not so good

things about making changes (decision balance) are tools to effectively use this counseling style. Motivation is seen as a fluctuating product of a journeyman's interaction with a patient. This interactive style powerfully influences a patient's resistance, compliance with treatment, and positive change. Readiness to change is elicited from the patient, not from imposition by the counselor. It is not productive for clinicians to engage a patient in such a way that the relationship becomes adversarial, making the situation even more difficult.

Here is a point to ponder regarding resistance. If the patient accepts his or her diagnosis, agrees to go to residential treatment, or starts taking his or her medication based on having been "convinced" this is the right decision to make, then we deem our skills effective and successful. It neglects the fact that, in the process of convincing our patient to submit to our will because we know what is right for him or her, there are two negative consequences. First, the act of "convincing" can be a difficult, confrontational, and uncomfortable process for the patient and wholly unnecessary. Second, it makes the patient's commitment to change less likely.

Support self-efficacy

Self-efficacy refers to a patient's belief in his or her ability to resolve problems and make positive changes. Acting as a self-fulfilling prophecy, your expectations of a patient may affect the outcome. One of your tasks is to enhance the patient's confidence in his or her capability to cope with obstacles and to succeed in change. The journeyman respects and affirms the patient's right and capacity for self-direction rather than telling them what to do. The emphasis is on informed personal choice. Constructive behavior change is more likely to occur when a patient discovers an intrinsic desire to change. MI is more than its associated skills and techniques. It is a way of being a patient.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

409. Description of motivational interviewing

1. Define motivational interviewing.
2. In the autonomy component of MI, what position does this method call on the clinician to take with regard to a client's decision to change his or her current behavior?

410. Principles of motivational interviewing

1. What four principles guide the application of motivational interviewing?
2. Explain the term *self-efficacy* as it pertains to motivational interviewing?

1-6. Using Patient Placement Criteria in Patient Evaluations

The American Society of Addiction Medicine (ASAM) developed the patient placement criteria in an effort to standardize care being provided to patients with substance-related disorders. The patient placement criterion uses six dimensions to evaluate the patient for varying levels of treatment. Technicians should be familiar with the patient placement criteria. Using the patient placement criteria, technicians can match patient's needs with the appropriate services.

411. Assessing detoxification services

Before a person can be treated for abusing a substance, he or she must be free from the immediate effects of the substance. A client will need some time to detoxify from the substance. Can you imagine a drunk patient trying to present himself or herself logically in either a group or individual session? The first dimension of the ASAM criteria deals specifically with detoxifying a patient.

Dimension 1, Acute intoxication and/or withdrawal potential

Acute intoxication and/or withdrawal potential establishes the criteria used to determine appropriate detoxification services. Acute intoxication, or signs and symptoms of severe withdrawal are medical emergencies that must be addressed immediately. Assessment in this area calls on the journeyman to evaluate a variety of factors simultaneously.

Sample questions

When assessing each substance abuse patient to determine the appropriate level of detoxification, as a minimum it is critical to address the following list of questions:

- Does the patient meet the criterion for a substance-related disorder?
- What is the patient's history of use?
- What is the patient's score on the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)?

Generally speaking, a score of less than 8 or between 8 and 10 indicates a high probability withdrawal can be managed in an outpatient setting. A score between 10 and 15 may indicate the patient's withdrawal might be better managed in a partial hospitalization setting. Any score higher than 15 may indicate the patient should be hospitalized to manage the withdrawal safely. Of course, these general guidelines should be evaluated in conjunction with all the information gathered from the initial patient evaluation.

- Is the patient currently experiencing signs and symptoms of withdrawal?
- What is the patient's past history of withdrawal?
- When did the patient last use a substance and how much was used?
- How capable is the patient of following treatment recommendations?
- What kind of support does the patient have in his or her current living situation?

General information

The previous, of course, are just some examples of questions that may need to be answered when evaluating for detoxification services. As you can see, the more complex the answers to these questions are, the greater the need for intensive detoxification services. Throughout the process, the counselor must continually assess the safety of the patient. Over and over again the counselor must ask, "Can this patient's situation be safely managed at the level of care selected?" Remember, intoxication or withdrawal can quickly become medical emergencies. In any case, the patient must have access to medical support should the need arise.

412. Assessing for treatment services

Detoxification is the first dimension of the assessment. There are five more dimensions used to evaluate the patient's need for treatment. The information obtained in all six dimensions form the basis for treatment recommendations.

Dimension 2, Biomedical conditions and complications

In this dimension, the counselor evaluates whether there are medical conditions that need to be addressed which could complicate treatment. Identify any chronic conditions that may affect treatment. For instance, does your patient have diabetes or high blood pressure? These are a few examples of conditions that could complicate treatment.

Dimension 3, Emotional, behavioral, or cognitive conditions or complications

This dimension addresses any coexisting mental illnesses. The journeyman's knowledge of dual disorders is put to good use. If there are coexisting conditions or complications, this may call for the journeyman to use referral sources or to work collaboratively with other services.

Dimension 4, Readiness to change

In this dimension, the journeyman assesses the patient's motivation and desire to make changes. Does the patient actively object to treatment? Does he or she feel coerced into treatment? The patient's investment in treatment and compliance with treatment recommendations is often an indicator of his or her desire to change.

Dimension 5, Relapse/continued use/problem potential

The journeyman assesses the patient's immediate danger of the patient's continued substance usage. Assess the patient's coping skills and likelihood of relapse. Identify triggers which are likely to cause potential problems for the patient. Is the patient capable of resisting the temptation to use the substance of choice? What is the patient's current level of stress? Assessment in this area calls for the journeyman to make an estimation of the patient's capability for managing cravings, avoiding triggers, and resisting impulses to use. In addition, it calls for the journeyman to assess factors that could affect the patient's ability to successfully manage abstinence.

Dimension 6, Recovery environment

Here, the counselor assesses any factors within the patient's environment that could impact his or her ability to be successful in the program. Identify dangerous psychosocial factors that pose a threat or exacerbate stressor, triggers, or likelihood of relapse. If a person tells you he or she is coming into the clinic for his or her crack addiction, chances are he or she is set up for failure—that's if he or she is leaving treatment to go live with his or her three roommates who sell cocaine. Identify resources in the sense of sober friends, activities, academic, or vocational activities that are positive influences on the patients' recovery.

General information

These ASAM dimensions are used not only to select an appropriate level of treatment, but also to evaluate continuation of treatment and to determine when it is appropriate to discharge the patient from treatment. Additionally, the information gathered in these dimensions may also be used to transfer patients from one level of care to another, based on changing needs. The need for a thorough evaluation and continued evaluation cannot be overstated. The counselor must have collected quite a bit of information to effectively match the patient's needs to an appropriate level of care. When the patient has the benefit of receiving an appropriate level of care, it increases the likelihood that this treatment will be effective.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

411. Assessing detoxification services

1. What establishes the criteria used to determine appropriate detoxification services?
2. In addition to the questions ascertaining the appropriate detoxification services, what else should the counselor continually assess?

412. Assessing for treatment services

1. Which dimension forms the basis for treatment recommendations?
2. During which dimension does the counselor assess factors within the patient's environment that could impact his or her ability to be successful?

1-7. Intake and Orientation

There are many beneficiaries in your community; knowing which ones are eligible for care in your treatment setting can be challenging. Many retirees and their dependents joined the military in an era of promised "free lifetime healthcare" which has been greatly curtailed over the last 10 years.

In today's medical treatment facility (MTF) a variety of options for accessing mental health care exist, particularly for the active duty military family member. Determining appropriateness for care has changed very little over time. Manning, contingencies, local mandates, and the dependent patients' options within the community will often dictate access to your MTF, barring an emergency.

In this section you will review the priority type of each beneficiary group and briefly review issues relating to supplemental care. Furthermore, you will explore eligibility requirements, administrative tasks, and legal requirements as they relate to patient's participation in your programs. You will also study an overview of program objectives and operations, including the patient's rights and obligations. The patient's participation in his or her healthcare represents a commitment to positive outcomes and should always be encouraged. After all, patients are the ultimate stakeholders in treatment outcomes.

413. Determining eligibility and appropriateness for services

A client cannot just walk up off of the street and be seen in one of our clinics. There are certain rules we have to follow to make sure we are giving the proper treatment to the proper client. All military medical facilities have certain eligibility and appropriateness standards to maintain.

Eligibility

Air Force MTFs provide health care services to military members and other authorized individuals. This short statement vaguely describes who is eligible for care at your particular MTF. Your business involves the delivery of high-quality care to people who are part of the world's greatest defense team ever assembled. Delivering high-quality care is an expensive business. Each member of the health care team must constantly look at how he or she delivers this care and determine ways to improve the

quality and reduce costs. One of the easiest ways to do this is to ensure patients treated in the MTF are eligible for Department of Defense (DOD) health care benefits.

So, who *is* eligible for treatment in your facility? How would you answer that question if posed by a prospective patient? What should you know about the person before providing an answer? Is he or she active duty or retired? Are you confident enough to answer this person's questions? After studying this section, you'll know more about verifying patient eligibility and appropriateness for care, and will be able to answer this question with greater confidence.

Under normal peacetime conditions, eligible beneficiaries (those authorized medical care in the MTF) are provided routine outpatient care in MTFs using a standard appointment system within the capability and scope of the services available. Emergencies are always triaged and prioritized based upon the need of the patient/client (your specific clinic will delineate what constitutes an emergency and the appropriate response). There may be occasions, however, when the MTF commander must prioritize or limit care due to limited resources, change of mission, war, or other reasons. This lesson will look at the standardized priority for access to care universally in MTFs.

Priority of care

The military services administer the Uniformed Services Health Benefits Program (USHBP) IAW Title 10, United States Code, Chapter 55, Sections 1071 through 1088, 1090, 1093, 1095, and 1097. The USHBP identifies and categorizes beneficiaries who are eligible to receive care. This lengthy description contains a variety of beneficiaries and special provisions, to include exceptions to the rule, depending upon specific circumstances. You do not need to be familiar with the complete list of USHBP beneficiaries, but rather, be aware of where to locate the listing and how the beneficiary types are prioritized.

The following table shows the access priority for care in MTFs where TRICARE is implemented.

Priority Group	Beneficiary Type
1	Active duty service members
2	Active duty service members' family members enrolled in TRICARE Prime
3	Retiree, their family members, and survivors enrolled in TRICARE Prime
4	Active duty service members' family members who are not enrolled in TRICARE Prime
5	Retirees, their family members, and survivors who are not enrolled in TRICARE Prime

Supplemental care

This is non-elective specialized inpatient and/or outpatient treatment, procedures, consultation, diagnostic tests, supplies, or equipment in a non-military medical facility while one is an inpatient or outpatient of a military facility. This care is required to augment the course of care being provided by the military MTF. An example of this in the mental health setting would include inpatient psychiatric admission, inpatient substance abuse treatment, etc. Supplemental care includes services which cannot be accommodated by your local MTF.

Appropriateness

Appropriateness implies there must be compatibility or congruence between the patient, diagnosis, and the provider. In other words, does the clinic offer what the patient's treatment needs dictate, and is the staff sufficiently credentialed to provide the care? Simply because the patient is eligible for care in your facility doesn't necessarily mean you can accommodate his or her specific issues.

For example, a child is referred to your clinic from pediatrics with a variety of psychiatric complaints and questions from the pediatrician regarding disposition of this child. Conducting an assessment to ascertain the extent of the child's problems would be inappropriate if you do not have any services available for the child to follow-up. Conducting an assessment merely creates an unnecessary hurdle

for the child and could possibly delay treatment. Again, if the request for services is beyond your clinic's capabilities of providing this care it would be inappropriate for you to engage in a therapeutic relationship beyond finding resources that could accommodate this requirement.

Other services which are often not widely available in the military treatment community include sleep study, sex therapy, or biofeedback. Knowing where and how to access resources are very important in these cases. If your clinic's staff is not credentialed to provide any of these services it would be inappropriate, unethical, and possibly illegal to engage in providing these services.

Ensure the appropriateness of your referral when you coordinate with providers off-base or at another MTF. Taking the time to match the patient with the services offered can be invaluable in following through with the needed care. If you've ever been given directions that led to nowhere or were promised something that turned out to be less than expected, you more than likely lost momentum towards resolution. It takes an incredible amount of courage from some patients to seek help. If you undermine that courage by not taking an active interest and providing solid referral data, they may never seek help again.

414. Administrative procedures for admissions

With the closure of so many Air Force psychiatric inpatient units, the opportunity to familiarize you with the admissions process has diminished as well. However, this doesn't mean you should not be familiar with the admission process as well as the administrative protocol associated with admitting a patient. For the most part you can rely on the expertise of the admissions and dispositions (A&D) clerk to provide all of the administrative support for admitting your patient and ensuring all protocol has been followed. This luxury cannot always be available or afforded. In this lesson you will examine some of the more common administrative aspects of the admission process.

When the opportunity arises to participate or assist in the admission of a patient, you should seize the moment. Familiarize yourself with the process and protocol you will need to ensure is completed. This lesson will provide an overview of the necessary forms and their intended purpose as well as your role as a Mental Health Journeyman in this process.

When a patient arrives on a unit, or shortly thereafter, there are several administrative tasks you will need to accomplish. Several records and articles will normally be brought or sent to the unit, which make up an admission package:

1. AF Form 560, Authorization and Treatment Statement (original and 3 copies).
2. At least one 3 by 5 patient locator card. (Each unit may have different uses for these cards, so local policy will dictate whether additional cards should be sent.)
3. AF Form 577, Patient's Clearance Record.
4. Outpatient records when available.
5. The inpatient records on anyone who may have been received from another MTF by transfer such as aero-evacuation.
6. Any receipts for clothing or valuables that may have been deposited while the patient was in the admission office if initial contact took place there.
7. Any inpatient records from prior hospitalizations at your facility.
8. An identification armband.

Admission and forms use

Most of the forms identified above are maintained in a patient's inpatient chart. As we mentioned in an earlier lesson, the local policy determines exactly what forms will be maintained. The above items will normally be delivered by A&D personnel if the admission initially was conducted in the admissions office. However, initial work on the most of these forms must be conducted on the unit, usually by you the Mental Health Journeyman.

In addition to the forms listed above, let's take a brief look at some of the administrative procedures to admit a patient to your unit during normal duty hours.

AF Form 560

The AF Form 560 has several blocks that are circled to include block number 2 (Name), 7 (Date of Admission), 22 (Inpatient Unit), 33 (Primary Admission Diagnosis), 34 (Secondary Admission Diagnosis), and 37 (Admitting Provider). These blocks are the minimum information that must be completed by you the Mental Health Journeyman or the mental health care provider prior to sending the form to the A&D office. Admissions personnel will normally come to a unit, if necessary, to gather the rest of the needed data.

Patient identification band

One of the first items to be accomplished on the unit—if it is not already accomplished by A&D office—is to place the patient identification band (armband) on each new patient. Remind the patient that all patients must wear an identification band. This assists with identification prior to administration of scheduled procedures or medications.

SF Form 506, Clinical Record - Physical Examination

You should obtain and record a new patient's physiological measurements to include vital signs, temperature, height, and weight. While this may seem mundane and mechanical, keep in mind the importance of accuracy when establishing a baseline for further comparisons. If you are required to answer the top portion of the SF 506, you should also ask the patient his or her average weight and maximum weight at this time.

AF Form 222, Patients' Clothing and Effects

Regardless of where a patient's clothing and effects are stored, whether in a centralized room or on the unit, the administrative procedures are similar.

1. A patient checks the appropriate block in "Store Effects/Clothing" section of AF Form 222, Patient's Effects/Clothing Storage Tag, indicates any items to be stored and dates and signs it.
2. You then enter the description, quantity, etc., after item or in "Remarks" if applicable. Check AF Form 222, enter the date received, and sign it. The form is then filed in an alphabetical or numerical (registrar number) file at the place of storage.
3. Complete the "Patient's Stub" and give it to the patient to retain as a receipt.
4. Enter the patient data on the unit status board.

Patients' valuables

All patients should be urged to deposit their valuables and money with the designated custodian of patients' funds, usually the resource manager. Inform the patient that the facility cannot assume any responsibility for loss unless the valuables are deposited. At no time should valuables or money be retained by you or anyone in the nursing staff for safekeeping.

Searching personal effects

One area that deserves special mention involves the search of a patient's personal effects. Some facilities require a written statement in the admission note that the personal effects were checked by the Mental Health Journeyman or nurse. Some Mental Health Journeymen feel uncomfortable with this task. Keep in mind that it is necessary to ensure the safety of all patients and staff alike. Each unit will have its own operating instructions as to what is allowed on the unit. Items that you should be particularly alert for are weapons, illegal drugs, alcohol, and prescription drugs.

Unit status board

Each nursing unit will have a unit status board. This board serves to provide nursing personnel information on the current status of each patient assigned to that particular unit. Everyone assigned to

the unit is responsible for maintaining the status board. Most unit status boards are magnetic and equipped with various letters, numbers, and colors representing a key to make identification easier for staff while not revealing personal information to other patients. Normally, the board will have bedroom and bed numbers permanently affixed to it. After an admission, you should place the *patient's name* and the *name of the physician* responsible for the patient on the board next to the appropriate bed number.

If you are assigned to an inpatient unit, you should quickly orient yourself to the status board and what the specific items represent on the board. As you can guess, the unit status board, when properly maintained, can be a very helpful tool in determining a variety of information about a patient at a quick glance.

After-hour admissions

When a patient is admitted after normal duty hours, a custodian, usually the administrative officer of the day (AOD), is appointed by the facility. Although the AF Form 560 advises patients that this facility is available, it is a good idea to reemphasize this fact during the admission procedures.

Patients' cash, jewelry, and items of a similar nature may be deposited in the A&D office. However, personal firearms, knives with blades above the length permitted by law, or any other item or object that could be considered a menace to safety or health are not accepted for safekeeping by a custodian. These items are turned in to the security forces and a receipt is given to the patient.

415. Purpose of the consent for treatment

You would never enroll in a college course without reviewing a syllabus. You likely would have never joined the Air Force without knowing what was going to be expected of you and what expectations you had from the military as well. It only makes sense then that you would not seek any form of medical care without knowing what treatment would be performed or what the anticipated outcome would be.

Why do you need to obtain consent for treatment from your patient? What purpose does it serve? Do you think it would be correct for a clinician to conclude, "I know what's best for the patient. Now, if he or she will just do what I say, things will be better for him or her." Or do you feel as though patients are well-educated and savvy about treatment options and actively seek a participative form of care?

Anytime you seek medical care that requires even minor surgery, you are informed of the nature of the procedure, the risks, the anticipated outcome, etc. In essence, the provider is seeking your consent to proceed with the procedure. While we in mental health certainly do not perform medical care, we are engaged in treatment planning, which begs many of the same questions as a medical consent for treatment (what can be expected in the procedure, risks, outcomes, etc.).

Consent intent

The consent for treatment serves as a contract between you and your patient regarding agreed upon methods for resolving the patient's issue. That is not to say that the consent for treatment is set in stone. If the patient needs additional help, the consent can be vacillating. For instance, if the patient came to you seeking help with abstaining from alcohol and is diagnosed as alcohol dependent then the focus of treatment would be on the substance abuse. However, if in the course of treatment the patient reveals a history of chronic depression and the alcohol was simply masking the symptoms of this problem, the focus of treatment would then take on another aspect as well.

This participative decision making is usually based upon the patient's values and beliefs coupled with the provider's clinical knowledge. This ensures that patients are informed partners in their own care. Unlike most other areas of your MTF where patients are informed of the course of treatment they will undergo, services in the mental health world involve a participative investment. Patients are the primary stakeholders in treatment outcomes. We guide, advice, and suggest options, but ultimately

the patients make decisions or changes in their lives based upon expectations that both you and the patients have agreed.

The purpose of consent

There are many reasons why providers or patients talk about consent for treatment. We will look at the two primary reasons below:

Clinical purpose

The clinical purpose of consent is to enlist the patient's faith and confidence in the anticipated outcome of treatment. This is considered a major factor in contributing to the success of the treatment.

Legal purpose

The legal purpose of the consent for treatment is to provide those treating patients with a defense in the event the patient should take legal action against a provider for treatment. This is not to say that individuals providing care are simply immune from prosecution if a consent for treatment is in place—a provider is still accountable for negligence.

Clearly having a consent in place is advantageous to both patients and providers alike.

Patient's questions addressed

Your patients or their family may have questions that relate to anticipated treatment. Some of the more common questions include:

- What are my treatment options?
- What are the benefits of each of the options?
- What are the success rates?
- What are the risks if I do nothing?
- How long will I need to be in therapy or treatment?

Patient's refusal to sign consent for treatment

Some patients will refuse to sign anything regardless of what its purpose may serve. Patients who decline to sign the consent should simply be documented on the form of the patient's refusal. However, if the patient is command-directed to participate in treatment and refuses to do so, the patient's behavior should be documented and forwarded to the commander for further disposition. The behavior could be indicative or complimentary of the behavior that initiated the referral to your clinic.

416. Maintaining and safeguarding medical information

Safeguarding medical records is a fundamental expectation and right patients demand regarding privacy. Rightfully so, nothing can be more detrimental than the dissemination of private patient information to an unauthorized agent. You will often be privy to very personal and sensitive information. It is your duty and obligation to protect that information. Failure to do so can result in very real punishment including incarceration.

It's often very tempting to peruse the chart of a patient out of curiosity or simply to find out more about why the patient is coming to the clinic. Not only is that ethically improper it is also illegal. You should only peruse patients personal information if you have a valid need-to-know.

Perusing the chart and then passing along the information to others who do not have a need-to-know is extremely detrimental to the mental health community's reputation as a whole. Impressing peers or others with your knowledge of tantalizing details of a first sergeant or senior base official's personal life can be alluring. You will be asked many times by peers what you know about Master Sergeant Jones or Lt Col White's wife, etc. Maturity, responsibility and a commitment to protecting the integrity of patient care must be your compass of reason as it relates to patient information.

Even seemingly authorized instances of releasing information need to be handled with extreme care and based on informed decision making. As always, ASK if you don't know.

How should you proceed when a request for information from your patient's commander is received? Do you need a written or verbal consent from the patient or can you release the information without the patient's consent? What information can you release to the insurance company or commander, and how should you document the release? As a Mental Health Journeyman you may be asked these questions; would you know how to respond? You will be provided an overview of guidance in this lesson. You are encouraged to review all applicable guidance at your duty location which may be specific to your base. You will also be addressing Privacy Act, and Health Insurance Portability and Accountability Act (HIPAA) in the following paragraphs. While this lesson will not provide information regarding the Freedom of Information Act (FOIA), you should also familiarize yourself with guidance regarding this method of disclosure as well.

Maintaining medical records

The term medical records in this lesson can be used synonymously with mental health records, ADAPT records, and FAP records unless specifically identified otherwise.

The most important evidence we have of the quality of medical care rendered are health records. They must be accurate, complete, and legible. Medical records are owned by the agency that created them. I'll reiterate this point. Medical records are owned by the agency that created them. This means all records created in your clinic are owned by the US Air Force and managed by you and your clinic staff. Many times patients seeking to gain access to their records will demand their records stating "they are my records." The records do indeed contain information regarding the patient, but they are the property of the US Air Force.

Admissible in court

Medical records are considered hearsay; however, they are still admissible in court under the *business records exemption* to the hearsay rule providing certain requirements are met. Those requirements in short include:

Timeliness

The record must be made in the regular course of business. It must also be made at or near the time of occurrence of the event documented. This reinforces what you learned in technical training regarding the immediacy of documentation (documenting an interview or event as soon as possible).

Appropriate scribe

The records must be documented by a person whose duty is to record such information and the normal procedure is to record such information. This must be someone who is trained or credentialed to do so.

Rules for documentation

There are some very basic rules that must be followed regarding record documentation.

Legibility	Records must be legible and easily perused by other professionals.
Accuracy	Records must reflect accurate information regarding contact with a patient.
Correct errors	Draw a single line through any errors and annotate with initials, date, and time the item was deleted.
Just the facts	Do not opine, editorialize, or state your feelings. Simply document events or contact with a patient exactly as it occurred.
Be professional	Use universally acceptable language to describe the patients presenting condition. Avoid slang, personal put-downs, or defamatory statements.
Leave no blank space	Avoid leaving spaces blank. If something belongs in the space and you do not comment on it, at least initial the blank area to acknowledge the area.

All medical personnel must comply with the laws relating to maintenance and disclosure of records. Some Mental Health Services records requires additional steps be taken for the patient or requestor to gain access to information. You must periodically contact the Staff Judge Advocate's (SJA) office for changes to directives.

Privacy Act of 1974 (PL 93-579 AND 5 U.S.C. 552a)

All medical records are maintained within a system of records protected by the Privacy Act. Hard copy records are covered by the system notice "Medical Record System," which identifies the records, including secondary files, and inpatient and outpatient records of care received in Air Force medical facilities. AFI 33-332, *Privacy Act Program*, details the Air Force's approach to the program. Automated records are covered by "Automated Medical/Dental Record System." Disclosure to third parties is prohibited, except pursuant to the written consent of the individual to whom the record pertains or in specified limited circumstances.

Informing the patient

The DD Form 2005, Privacy Act Statement-Health Care Records, is NOT a consent form. It serves as evidence that, as prescribed by the privacy act, the individual was informed of the purpose and uses of the information collected and was advised of his or her rights and obligations with respect to supplying the data.

Every Mental Health, ADAPT, and FAP record must have a DD Form 2005. The form is completed by the patient on his or her initial visit regardless of the time covered. Do not have the patient complete the form again for each visit thereafter unless the form is missing from his or her record.

NOTE: The signature of the patient on the DD Form 2005 is not mandatory. The technician, provider, or secretary requesting the patient's signature should in no way coerce or even imply that the signature is necessary before treatment is given. If a patient refuses to sign; the technician, provider, or secretary should note such a refusal on the DD Form 2005 and sign it.

The Health Insurance Portability and Accountability Act (Public Law 104-191, 45 CFR, parts 160 and 164).

Most of you have HIPAA training at your individual bases. HIPAA was enacted 21 Aug 1996. The purpose of the Act is to improve the portability and continuity of health insurance coverage, improve access to long-term care services and coverage, and to simplify the administration of healthcare. A primary component of HIPAA administrative simplification provisions is the protection and privacy of individually identifiable health information. The HIPAA Privacy Rule governs this component and DOD 6025.18-R, implements the requirements of the HIPAA Privacy Rule listed below.

Use of information

Without written authorization from the patient or other disclosures required by law, patients protected health information can only be used for treatment, payment, and health care operations.

Acknowledgement of Notice of Privacy Practices

Each patient or guardian will receive a copy of the Military Health Service Notice of Privacy Practices. Documentation must be entered on the HIPAA acknowledgement label that is placed on the bottom middle of the outpatient record.

Disclosure or release

Records can be disclosed for various reasons without authorization by the patient. Complying with a subpoena, court order, or public health requirement as well as specific national security requirements are among the allowed disclosures.

Patient right to access

Patients have the right to access their health record information. As was addressed earlier in this lesson, the health record is the property of the United States Government; the information contained in the record belongs to the patient. Patients can request copies of information in their record just as allowed in the Privacy Act.

Accounting of disclosure

The patient can request an accounting of every disclosure for the previous six-year period back to 14 April 2003. This is limited to disclosures that are not part of treatment, payment, health care operations or disclosures authorized by the patient. Authorized disclosures must be tracked using a locally generated form until DOD implements the use of an automated accounting of disclosure tracking system.

Restrictions on information

According to HIPAA and the Mental Health Systems (MHS) Notice of Privacy Practices, a patient has the right to request restrictions of uses and disclosures of his or her medical or dental information. Requests for restrictions must be made in writing. However, it does not mandate that the MTF is required to agree to the restriction. The restriction should be denied if the MTF couldn't reasonably accommodate the request, if it conflicts with this instruction or any other applicable DOD or Air Force directive, or for other appropriate reasons. The MTF commander, or designee, must act on requests to restrict information in a timely manner and do so in writing. No restriction shall be effective above the management authority level that an authorized person agreed to it. No restriction shall be effective unless the person agreeing to the restriction is actually authorized to agree to it and establishes a written record on the restriction. The needs of the patient should be weighted with the burden that would be put on the facility to comply with the request. If granted, the patient should be informed that the restriction is not permanent and only applies to the individual or MTF that grants the request for which it is requested and does not transfer to another individual or MTF.

Reviewing and releasing information

Information in the records is personal to the individual and must be safeguarded properly. Take every precaution to avoid compromise of the patient's treatment information. You have the additional obligation of protecting not only the patient's Mental Health Service record, but also the OPR. Access to the records is restricted to authorized medical personnel with a "need to know" except in certain situations discussed in this lesson. Before releasing information to medical personnel, be sure that their access to those records is authorized and necessary in the performance of their duties.

Procedures for safeguarding information

As a Mental Health Journeyman, you have a responsibility to safeguard patient information; therefore, you must know the on-base resources available to assist you. These resources include your medical legal representative and the SJA staff. These folks can be an excellent resource for you to consult with prior to releasing information if at any time you have questions. If in doubt, contact them and be patient. There is yet to be an emergency *Release of Information* request where the clinician hadn't had the opportunity to consult a base legal representative prior to the release.

It is your responsibility to limit access to all open record storage areas and electronic records to authorized personnel only. Authorized personnel are defined as personnel who, through a verification process, have presented a valid requirement to access the records. There are negative legal implications for individuals who release medical information to individuals who are unauthorized to have the information. Be very cautious and ask questions if you are unsure. Below you will examine some instances where releasing records are authorized under certain circumstances.

Releasing medical information with consent

Upon written request, a patient may request a copy of the contents of his or her medical records be released directly to himself or herself. The patient can also submit a written request to have copies of the record released to an authorized individual or to his or her legal representative.

Adverse effects due to the release of information

If the provider of care, or if the provider is no longer available, a designated provider, determines that the direct disclosure of information contained in the medical record should not release information to the patient because he or she feels the information could have an adverse effect, the provider has to make a decision. The provider can choose to not share the information or the disclosure is made to a physician named by the individual, or to a person qualified to make psychiatric or medical determinations.

Further release not authorized

Information contained in the medical records cannot be released to any person or agency without the written consent of the patient concerned (with the exception of a court order or investigation discussed later in this lesson). When information is released to a third party (i.e., insurance company or another civilian medical facility), further release isn't authorized without the consent of the patient, his or her legal representative, or the agency having the original records ownership.

The same is true for information obtained for inclusion in records maintained in the clinic. You cannot re-release information obtained from another facility and maintained in the clinic's chart as the government does not have the original ownership of that material.

Information limit

How much information is enough information? Only enough information to accomplish the purpose for which it's requested is furnished. Do not volunteer additional information that is not requested.

Releasing medical information without consent

There are three instances when medical information may be released without a patient's consent.

Proper and legal need

Medical information is released, upon request, to other departments and agencies (federal and state), that have a proper and legitimate need for the information. For example, the Veterans Administration or the State Office of Workers Compensation programs often request information to process a claim for which the person's psychiatric or psychological history is relevant.

Public interest

Medical information is released upon the request of medical research or scientific organizations or other qualified researches when, in the opinion of the releasing authority, its release is legal and in the public interest. Names and social security numbers of parties should be deleted prior to release.

Office of Special Investigation

Medical information is released to the Office of Special Investigation (OSI). A special agent of the OSI is granted access to records upon proper identification and specific supporting documentation outlined below. The agent must sign a dated statement that identifies the file reviewed and the date the review occurred. This is maintained in a file separate from the patient's chart. Specific documentation that must be provided includes:

- **Identity**—Identify the record to be examined. The agent must provide documentation simply to review the record even if he or she doesn't make a copy of the record.
- **File number**—Identity of the investigation (OSI case file number) for which the record is being examined.

- **Certificate of requirement**—A certification by the examiner that the examination is required as part of the official examination.
- **Identification of material and a receipt**—An identification of any copies of materials furnished to the agent and a signed receipt.

Exceptions to release of information

There are very specific laws relating to records that contain information regarding alcohol and drug abuse. These laws take precedence over all other directives pertaining to access of information. Health records (inpatient and outpatient) that contain reference to drug or alcohol abuse or rehabilitation must be reviewed by the Staff Judge Advocate for a determination of their releasability and for guidance on the nature of the reply.

NOTE: Original health record documents are NOT released to any person or agency outside the executive branch of the Government. Copies of pertinent pages of the record can be released as long as the requirements we discussed above of such a release are met. When in doubt...ASK!

Honoring requests for medical information

The MTF commander is responsible for approving all requests for release of information. The MTF commander almost always uses his or her authority to designate responsibility for these duties to clinic officer in charge (OIC) or the Mental Health Services record custodian. This is usually the noncommissioned officer in charge (NCOIC) or superintendent. Thus, the importance of familiarizing yourself with rules regarding what can and cannot be released.

If the information or access to health records is to be provided to non-medical personnel with a proper and legitimate need, such as OSI agents, the MTF commander or his or her representative determines what information is pertinent to the request. The requester will sometimes ask for professional assistance in understanding the content of the records. If there is any doubt as to whether the requester has proper or legitimate need for the information, ask the person to state the purpose for which the medical information is to be used and ask questions of your supervisors.

Sensitive medical information

Information that may affect the patient's morale, character, medical progress, or psychological well being is considered sensitive. Drug and alcohol abuse, rape, child or adult abuse, and possible claims against the government are examples of highly sensitive records. To protect the sensitive nature of the information, stamp records or documents **SENSITIVE MEDICAL INFORMATION** before release or referral outside the medical facility. Then, place them in a sealed envelope stamped **MEDICAL INFORMATION-FOR USE BY AUTHORIZED PERSONNEL ONLY**.

Records are hand-carried by trustworthy personnel *only*. For example, if a child is being treated for suspected child abuse injuries, it would not be appropriate for the parents to hand-carry the child's records to and from clinics and ancillary services when the record may contain possible incriminating evidence. In cases like this, the provider or Family Advocacy personnel must inform outpatient records personnel that the records contain sensitive medical information and should be safeguarded or sequestered, which we will discuss later.

Use a locally developed transmittal letter or the form furnished by the requester when an insurance company or other agency requests information. Prepare the transmittal letter or form in two copies—send the original to the requester, file the second copy in the mental health services record.

Use of DD Form 877, Request for Medical/Dental Records or Information, is simple and universally recognized for obtaining records within the federal government. Other DOD MTFs, Veteran's Administration (VA), Federal Prison System, and National Personnel Records Center (NPRC) to name a few use DD Form 877 to request information or records. The DD Form 877 is a detailed form, and can be used for either a permanent or a temporary transfer of information. If you receive a DD Form 877, send the record and original copy of the DD Form 877 back to the requesting government

care facility (follow the instructions for “addressee” preprinted on the back of the form). It is always a good practice to maintain a copy of the record until the requester has confirmed receipt of the original. An accountability system should be implemented as part of your file plan to maintain DD Form 877s; thereby tracking records you have forwarded to other governmental agencies.

417. Overview of program rules, goals, objectives, and operations

Without a clear mission statement or plan of operation we all drift aimlessly, like a ship with no sail. This, of course, will lead to no final destination.

Operating with a clear visible mission statement is important for both the staff and patients alike. Collectively, staff and patients work as stakeholders to accomplish a common goal. Operating without a clear mission results in the organization or clinic bouncing from one apparent opportunity or crisis to the next, and is much less likely to focus on any one final outcome.

Orientate yourself to all of the goals associated with the program you are working. You should do this immediately upon arrival so you can begin striving towards the common goal of your peers.

This lesson will look at goals for the programs under Mental Health Services, as well as some of the rights and obligations of patients as our customers.

All of the programs under the mental health umbrella must have clear sense of organization, direction or vision, and yes, even limitations. Orientation should occur during the initial screening. Don’t overwhelm your patient with reams of paper detailing every nuance of your program during the initial screening, but be clear and informative.

Alcohol and Drug Abuse Prevention and Treatment Program

AFI 44–121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, Para. 3–1, Program Objective, clearly outlines what the expectations are from the Air Force regarding ADAPT. You’re entrusted with making it happen. The objective of the ADAPT program as described in the AFI is as follows: “To promote readiness and health and wellness through the prevention and treatment of substance abuse; to minimize the negative consequences of substance abuse to the individual, family, and organization; to provide comprehensive education and treatment to individuals who experience problems attributed to substance abuse; return individual substance abusers to unrestricted duty status or to assist them in their transition to civilian life, as appropriate.” Wow! That is seemingly a daunting responsibility and task.

Identifying and articulating your program goals, objectives, rules, and operations provides the foundation from where the patient can begin. Your program should have clear and achievable goals and objectives. The *goal* can be defined as the ultimate achievement or accomplishment and the *objectives* is how you plan on reaching that point.

Rules for ADAPT patients need to be clear, tangible, and consistent. Explain the “rules” to the patient prior to engaging treatment. Have you ever had the feeling someone was making up rules as they went along? A Patient Agreement Sheet, signed by the patient to acknowledge the program rules, will suffice. For instance, he or she needs to know that merely being present at group is not a demonstration of participation, and that abstinence is mandatory not a recommendation and they are subjected to random breathalyzers.

Detail the operations of the clinic to the patient. This includes the limitations as well. Explain clinic hours of operation and when you can be reached. Explain clinic on-call procedures and what constitutes an emergency.

Family Advocacy Program

IAW AFI 40–301 is comprised of the following three primary areas:

1. Prevention services.
2. Maltreatment intervention.

3. Special needs identification and assignment coordination process.

Each of these areas is unique; however, they all come together to support the objective of the FAP by promoting family and community health, and resilience and advocates for nonviolent communities.

Some 4C0X1s feel the FAP brings out the best and worst in people. There are patients who may be very hostile and consider you and the FAP staff as meddling in their personal lives. This can be very challenging and may weigh heavily on you emotionally when dealing with victims of abuse. Yet, there can be a rewarding aspect, particularly when dealing with a special needs family and new young parents who are forever grateful for your guidance. The importance of the patient understanding how your program operates cannot be underestimated. Promoting and marketing this program to the community is key to its success, particularly as it relates to prevention.

Mental health clinic

The clinic's overall goal is usually in tandem with the MTF's goals and mission statement. As a journeyman you may be asked to submit suggestions for clinic goals. Most certainly, you'll be asked to support the goals and objectives already in place.

As some of you may already be aware, and many are finding out, there continues to be a stigma unfairly associated with the mental health clinic. While this has decreased with the help and reassurance of Air Force leadership, it is often a persona we, as clinic staff, have either perpetuated or simply haven't done enough to discount. Clear articulation regarding the limits of confidentiality prior to treatment and the expectations the patient can anticipate from the clinic is a step towards clarification. Remember, any perceived or actual adverse action that comes from a visit to the clinic is usually precipitated by the patient's unacceptable behavior. Furthermore, it's the role of the patient's commander to dole out disciplinary action if necessary; not the mental health clinic. The clinic's primary role is to ensure fitness for duty and make recommendations based upon that premise.

Do you know your target population? Do you know your organizations limitations? What are your hours of operation, and how are you reached after normal duty hours? What constitutes an emergency? Identify your capabilities and articulate your "scope of care" to your patients. It's not enough that your staff and peers know how and when you operate—it's your customers who "keep you in business."

418. Patient's rights and obligations

As in society, your patient has rights. The rights of patients appear in several venues including locally created lists; those created by inspection agencies and individual states. Even Congress has passed legislation to protect the rights of the patient. For the most part, these rights are an extension of the rights of an ordinary citizen. We will examine some of the patient's rights later in this lesson.

Your patient has rights and obligations which must be respected. To the astonishment of some folks, patients do have obligations. Yes, patients have obligations as it relates to treatment outcomes. Gone are the days of the patient seeing the provider who was ultimately responsible for 'fixing' the patient's problem. Honoring patients' rights are paramount and the patient's bill of rights goes to great lengths to ensure the respect of a patient's cultural, psychological, spiritual and personal values, beliefs, and preferences.

Specific rights

Beginning in the early 1800s with the formal recognition of mental illness until present day treatment, patients' rights have come a long way. As was mentioned earlier, the rights of patients have been guaranteed by Congress in the Mental Health Systems Act (MHSA), which among other things created the Mental Health Bill of Rights. The Joint Commission has been at the forefront in tailoring specific rights and ensuring compliance nationwide.

Patient's rights

The role of a patient can make someone feel as if he or she has somehow lost his or her rights as a person or citizen. It's for this very reason the Patient's Bill of Rights has been so significant. Patients' rights are important because the health professional is in a position of enormous power, whereas patients may be coerced into accepting a form of treatment they would not have chosen if more information were available.

Joint Commission Bill of Rights

The Joint Commission's list of Individual Rights is periodically updated, and you will be inspected on these items when your unit's accreditation is initiated/reviewed/renewed. Review each and ask, are you, as part of the clinic team, meeting the element of performance, and can you produce evidence of meeting the standard? Please review the *Comprehensive Accreditation Manual for Behavioral Health Care*, focusing on the elements of performance to ensure you are meeting these requirements.

Joint Commission's Patient's Individual Rights

- The organization respects the rights of patients.
- Patients receive information about their rights.
- Patients are involved in decisions about care, treatment, and services provided.
- Informed consent is obtained.
- Consent is obtained for recordings or filming made for purposes other than the identification, diagnosis, or treatment of the patients.
- Patients receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services.
- Patients have the right to refuse care, treatment, and services in accordance with law and regulation.
- Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes.
- The organization respects the patient's right to and need for effective communication.
- The organization addresses the resolution of complaints from patients and their families.
- The organization respects the needs of patients for confidentiality, privacy, and security.
- Patients have a right to an environment that preserves dignity and contributes to a positive self-image.
- Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
- Patients have the right to pain management.
- Patients have a right to access protective and advocacy services.
- The organization protects research subjects and respects their rights during research, investigation, and clinical trials involving human subjects (applicable to organizations participating in research).
- In organizations that provide opportunities for work, a defined policy addresses situations in which patients work.
- Patients have a right to exercise citizenship privileges.

Patient obligations

Shouldn't your patient expect to begin noticing some alleviation from his or her original presenting symptoms? The answer is yes, BUT, it will require work on the patient's part as well. Your patient has obligations to assist in his or her own recovery or wellness. When you enter into a contract, there

are expectations from both parties to fulfill their obligation. Treatment is no different. Despite all your efforts, guidance, suggestions, and hours spent formulating treatment plans the patient is doomed for failure unless he or she is a vested stakeholder in the outcome. This is the patient assuming responsibility for his or her care. Understanding this complimentary relationship between provider and patient will save you countless hours of worry and eventual burnout due to self flagellation.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

413. Determining eligibility and appropriateness for services

1. Who identifies and categorizes beneficiaries who are eligible to receive care?
2. What is supplemental care?
3. What does *appropriateness* imply in regards to providing services at your medical facility?
4. What are some examples of services not widely available in the military treatment community?

414. Administrative procedures for admissions

1. Whose expertise can you usually rely on to provide administrative support for admitting a patient?
2. Which areas are considered the minimum information that you, as the Mental Health Journeyman or the mental health care provider, must complete on the AF Form 560?
3. During an admission to a medical facility, what items should you be alert for when searching a patient's personal effects?

415. Purpose of consent for treatment

1. What is the *clinical purpose* of the consent for treatment?
2. What should you do if a patient refuses to sign the consent for treatment?

416. Maintaining and safeguarding medical information

1. What is the procedure regarding correcting errors in documentation?
2. What purpose does the DD Form 2005 serve?
3. What should you do if a patient refuses to sign the DD Form 2005?
4. What is the purpose of the HIPAA?
5. How much information should you release if you receive an authorized request for information?
6. What information must an OSI agent provide to review a record?
7. What is considered sensitive medical information?

417. Overview of program rules, goals, objectives, and operations

1. What is a goal and objective?
2. Who does the mental health clinic usually have its goals in tandem with?

418. Patient's rights and obligations

1. Why is it important to adhere to patients' rights?
2. Treatment plans are doomed for failure unless a patient does what?

Answers to Self-Test Questions

401

1. It can limit the journeyman's ability to be accepting of a patient.
2. Acknowledging how a patient feels without actually feeling the same way.
3. The patient will view the interviewer as the authority figure.
4. If the interviewer remains in a position of authority, the patient will become increasingly dependent upon the interviewer and expect the interviewer to solve the patient's problems for him or her and the patient may continue to avoid taking responsibility for his or her life. Neither of these is good for the patient, as they prevent the patient from experiencing any degree of personal growth and eventual recovery. Secondly, it is critically important the interviewer establish an alliance with the patient. This will help the patient to understand that we are working as a team, in unison, and for a common goal. It will also help the patient understand that he or she must take an active role in the process of improving his or her situation or emotional health.
5. Being self-aware, capable of conveying acceptance, being observant, and possessing empathy are critical characteristics.

402

1. Responding verbally to what is being said without changing the subject.
2. Who, what, where, when, or how.
3. Is, are, do, or did.
4. It focuses attention on current feelings, encourages the patient to talk, and provides feedback to the patient on how the interviewer sees the situation affecting the patient emotionally.
5. It communicates to the patient that you have a clear understanding of what he or she is going through because, perhaps, you have been through something similar. Self-disclosure also validates your empathy.

403

1. In the fact that his or her spouse or supervisor is highly recommending he or she seeks assistance.
2. It will allow you to become familiar with any previous psychiatric treatment, chronic medical conditions, or injuries that may be related to the patient's visit. Review and note any medications the patient may be taking. Recent or current medication usage can contribute to or mask the patient's presenting complaint.
3. If the patient is self-referred, cooperative, cognizant, and a good historian.
4. Suicidal and homicidal ideation, threats or gestures; threats to national security, or inability to perform PRP responsibilities.

404

1. CDEs, an allegation of family maltreatment and any substance abuse incident will generally initiate a mandatory referral.
2. Despite sometimes being victims of abuse themselves for fear of reprisal by the alleged offender, fear of getting the referred member in trouble, or fear of losing their livelihood if the sponsor is prosecuted or removed from the military.

405

1. Parents, siblings, peers, and coworkers.
2. Allows you to better communicate and suggest treatment options for the patient.

406

1. Frequency.
2. It will give you an idea of increased tolerance and or a progression to a more powerful substance.

407

1. Gather objective data which may be helpful in determining etiology, diagnosis, treatment, and prognosis.

2. Such things as a change in voice pitch, change in eye contact, tears, heavy sighs, overt swallowing or other physical responses, and hesitancy to answer particular questions, may all be indicators that you have touched on an area of importance to the patient.
3. It eliminates embellishment and personal emotions that are often inserted into an observation.

408

1. A patient's internal emotional tone.
2. The observable external expression of the patient's internal emotional tone.
3. Often a sign of emotional illness or more serious psychological problem.
4. Appropriate, inappropriate, flat, blunted, labile.
5. Mental awareness or fully informed.
6. Remote memory.
7. A learning deficit, or organic brain disease.
8. The patient's ability to interpret and mentally organize the flow of conversation or events occurring around him or her.
9. A patient's degree of understanding and capacity to understand what is causing his or her distress or illness.
10. Past decisions he or she has made in dealing with situations and problems of everyday life.
11. Hallucinations and illusions.
12. The more specific the plan the higher the risk for suicide.

409

1. MI is a patient-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.
2. Respect the patient's right for self-determination, regardless of whether or not the clinician agrees with the decisions of the patient.

410

1. Express empathy, develop discrepancy, roll with resistance, and support self-efficacy.
2. Refers to a patient's belief in his or her ability to resolve problems and make positive changes.

411

1. Acute intoxication and/or withdrawal potential.
2. Safety of the patient.

412

1. All six dimensions.
2. Dimension 6, Recovery environment.

413

1. USHBP.
2. This is non-elective specialized inpatient and/or outpatient treatment, procedures, consultation, diagnostic tests, supplies, or equipment in a non-military medical facility while one is an inpatient or outpatient of a military facility.
3. There must be compatibility or congruence between the patient, diagnosis, and the provider.
4. Sleep study, sex therapy, or biofeedback.

414

1. The A&D clerk.
2. This form has several blocks that are circled to include block number 2 (Name), 7 (Date of Admission), 22 (Inpatient Unit), 33 (Primary Admission Diagnosis), 34 (Secondary Admission Diagnosis), 37 (Admitting Provider).
3. Weapons, illegal drugs, alcohol, and prescription drugs.

415

1. To enlist the patient's faith and confidence in the anticipated outcome of treatment.
2. Simply document on the form the patient's refusal to sign.

416

1. Draw a single line through any errors and annotate with initials, date, and time the item was deleted.
2. It serves as evidence that, as prescribed by the Privacy Act, the individual was informed of the purpose and uses of the information collected and was advised of his or her rights and obligations with respect to supplying the data.
3. Note the refusal on the DD Form 2005 and sign it.
4. To improve the portability and continuity of health insurance coverage, improve access to long-term care services and coverage, and to simplify the administration of healthcare.
5. Only enough information to accomplish the purpose for which it's requested is furnished. Do not volunteer additional information than is requested.
6. File number, identity of the investigation (OSI case file number) for which the record is being examined, certificate of requirement, (a certification by the examiner that the examination is required as part of the official examination), identification of material and a receipt.
7. Information that may affect the patient's morale, character, medical progress, or psychological well being.

417

1. The goal can be defined as the ultimate achievement or accomplishment and the objectives is how you plan on reaching that point.
2. The MTF.

418

1. Patients' rights are important because the health professional is in a position of enormous power; whereas patients may be coerced into accepting a form of treatment they would not have chosen if more information were available.
2. Becomes a vested stakeholder in the outcome.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

Do not return your answer sheet to the Extension Course Program (A4L).

1. (401) What occurs when the interviewer unconsciously projects emotions, thoughts, and expectations from past life experiences onto the patient?
 - a. Transference.
 - b. Self-awareness.
 - c. Verbal following.
 - d. Counter-transference.
2. (402) Which of the following is *not* an attending behavior?
 - a. Display attentive posture.
 - b. Use verbal following.
 - c. Clarification.
 - d. Make eye contact.
3. (402) What interview process skill requires the patient to elaborate on a vague, ambiguous, or implied statement?
 - a. Explanation.
 - b. Clarification.
 - c. Reflection.
 - d. Paraphrase.
4. (402) What interview process skill involves selective attention given to the cognitive parts of the patient's message that are translated in the interviewer's own words?
 - a. Clarification.
 - b. Paraphrase.
 - c. Reflection.
 - d. Transition.
5. (402) What interview process skill, when employed, is a sign of competence and self-awareness?
 - a. Silence.
 - b. Self-disclosure.
 - c. Direction and control.
 - d. Know your boundaries.
6. (403) When reviewing a patient record what can contribute to or mask the patient's present complaint?
 - a. Recent or current medication usage.
 - b. Previous psychiatric treatment.
 - c. Information that has been removed by the patient.
 - d. Emergency room visits.
7. (403) As a Mental Health Journeyman, you have access to all of the following records for the self-referred patient *except*
 - a. outpatient medical records.
 - b. family advocacy records.
 - c. mental health records.
 - d. personnel records.

8. (404) A CDE allows you to contact all of the following *except* the commander-directed individual's
 - a. commander.
 - b. supervisor.
 - c. family.
 - d. peers.
9. (405) Which is *not* a key area of a patient's social history?
 - a. Social.
 - b. Substance use.
 - c. Home environment.
 - d. Occupational/academic.
10. (405) What area of the social history is explored in depth to gain a complete grasp of your patient's capabilities?
 - a. Social.
 - b. Substance use.
 - c. Home environment.
 - d. Occupational/academic.
11. (406) When exploring a patient's substance use history, in which of the following areas are you trying to determine if the patient has developed tolerance?
 - a. Frequency.
 - b. Progression.
 - c. Substances used.
 - d. Severity/amount used.
12. (406) When exploring a patient's substance use history, in which area do you identify any adverse consequences experienced from substance usage?
 - a. Frequency.
 - b. Progression.
 - c. Substances used.
 - d. Severity/amount used.
13. (407) What should be very limited in the MSE?
 - a. Documentation.
 - b. Subjectivity.
 - c. Objectivity.
 - d. Wordiness.
14. (408) Which of the following is *not* a primary assessment area of the MSE?
 - a. Appearance and behavior.
 - b. Physiological functioning.
 - c. Cognitive functioning.
 - d. Emotions.
15. (408) Which primary type of affect refers to the patient who is *grossly diminished* in his or her range of emotions?
 - a. Inappropriate.
 - b. Blunted.
 - c. Liable.
 - d. Flat.

16. (408) What would you be assessing if you asked a client about something he or she said previously during the interview?
 - a. Immediate recall.
 - b. Recent recall.
 - c. Recent memory.
 - d. Remote memory.
17. (408) What area of the MSE examines whether the patient's thoughts are considered odd or peculiar?
 - a. Thought content.
 - b. Thought process.
 - c. Intelligence.
 - d. Insight.
18. (408) What common perceptual disturbance is categorized as a misperception or misrepresentation of real external stimuli?
 - a. Vision.
 - b. Illusion.
 - c. Delusion.
 - d. Hallucination.
19. (409) Which is a patient-centered, directive method for enhancing intrinsic inspiration to change by exploring and resolving ambivalence?
 - a. Collaboration.
 - b. Autonomy.
 - c. Evocation.
 - d. Motivational interviewing.
20. (410) Which element of MI validates ambivalence and resistance as being a normal part of the human experience?
 - a. Express empathy.
 - b. Roll with resistance.
 - c. Develop discrepancy.
 - d. Support self-efficacy.
21. (410) In MI, resistance is *not* viewed as a problem for the patient, but rather it is a skill issue for the
 - a. treatment team.
 - b. commander.
 - c. counselor.
 - d. family.
22. (411) When should acute intoxication or signs of severe withdrawal be addressed?
 - a. 24 hours.
 - b. 72 hours.
 - c. One week.
 - d. Immediately.
23. (412) What is the first dimension of assessment for substance abuse?
 - a. Detoxification.
 - b. Readiness to change.
 - c. Recovery environment.
 - d. Biomedical conditions and complications.

24. (412) In which assessment dimension would you identify any chronic conditions that may affect treatment?
- Detoxification.
 - Readiness to change.
 - Recovery environment.
 - Biomedical conditions and complications.
25. (412) Which dimension of assessment is used to identify dangerous psychosocial factors that pose a threat or exacerbate stressor, triggers, or likelihood of relapse?
- Detoxification.
 - Readiness to change.
 - Recovery environment.
 - Biomedical conditions and complications.
26. (413) When discussing priority of care, under which beneficiary type group does the active duty service member fall into?
- 1.
 - 2.
 - 3.
 - 4.
27. (413) In which example would it be inappropriate to engage in a therapeutic relationship with a patient?
- Evaluation for depression with credentialed staff and available appointments.
 - Evaluation of dependent child without credentialed staff and available appointment.
 - Evaluation for security clearance with credentialed staff and available appointments.
 - Evaluation of dependent spouse with credentialed staff and limited appointment availability.
28. (414) Which is *not* something you would place on a patient status board after admission?
- Name of the physician.
 - Patient's name.
 - Bed number.
 - Diagnosis.
29. (414) When a patient is admitted to an MTF, items which are deemed a menace to safety or health are turned in to the
- security forces.
 - inpatient unit NCOIC.
 - A&D Office.
 - MTF commander.
30. (415) The consent for treatment and participative decision making is based upon all of the following *except*
- patient's values.
 - patient's beliefs.
 - provider's values.
 - provider's clinical knowledge.
31. (416) Who owns the OPR?
- Patient.
 - Guardian.
 - US Air Force.
 - MTF commander.

32. (416) What venue is *not* allowed access to medical records without the patient's consent?
- a. OSI.
 - b. Proper and legal need.
 - c. Commander-directed.
 - d. Public interest.
33. (416) Who is responsible for approving all requests for release of information?
- a. MTF commander.
 - b. Mental Health Services OIC.
 - c. Outpatient Medical Records OIC.
 - d. Mental Health Services NCOIC.
34. (417) Which is *not* one of the three primary areas of the FAP?
- a. Prevention services.
 - b. Child placement services.
 - c. Maltreatment intervention.
 - d. Special needs identification and assignment coordination process.
35. (417) The Mental Health Clinic's goals are usually in tandem with the
- a. ABW.
 - b. MAJCOM.
 - c. MTF.
 - d. AF SG.
36. (418) Which act, passed by Congress, guarantees the rights of mental health patients?
- a. Mental Health Privacy Act.
 - b. Mental Health Systems Act.
 - c. Behavioral Health Systems Act.
 - d. Behavioral Health Privacy Act.
37. (418) What organization is at the forefront of tailoring specific rights and ensuring compliance nationwide?
- a. IMRHA.
 - b. CARF.
 - c. NMHA.
 - d. The Joint Commission.

Please read the unit menu for unit 2 and continue ➔

Student Notes

Unit 2. Addiction Models and Pharmacology of Abused Substances

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THERE ARE many models of addiction throughout the treatment community. As you become more familiar with the variety of treatment models employed today, you will likely adopt or come to favor a specific treatment approach. In this lesson we will study only two of them; the disease model of addiction and the biopsychosocial model of addiction. However, you are encouraged to research and examine other models to expound your knowledge base regarding treatment models.

2–1. Disease Model vs. Biopsychosocial Model of Addiction

There are many different theories debating how a person becomes an addict. There are many out there who believe the potential for addiction is something we are born with; certain mysterious factors are “turned on” inside of us over the course of growing up. There are others who believe that while the biological piece is important, it is more the psychological and social forces which drive individuals to become addicted to substances. We will discuss two more prevalent thoughts on the subject; the disease model and the biopsychosocial model of addiction.

419. Features of the disease model of addiction

The disease model of addiction is perhaps one of the oldest models still in use today. Dr. Benjamin Rush first proposed this model in 1810. His novel approach was certainly unique for his day and scoffed at by his critics when first presented. He called for the creation of a “sober house” where alcoholics would be confined and rehabilitated upon evidence of drunkenness, neglecting their business, or maltreatment of their family members. His proposal for the disease model included the same criteria we use today:

1. Loss of control over the use of the substance.
2. Continued use despite negative consequences.

In this section, you will study the basic concepts of the disease model of addiction. Let’s begin by looking at a couple of definitions you’ll need to be familiar with to understand the concept of this model clearly.

To properly understand this model of addiction, you must first understand what the terms “disease” and “addiction” mean. According to the Merriam-Webster Dictionary, the following definitions are provided:

- Addiction: Compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal.
- Disease: A condition of the living animal or plant body or of its parts that impairs.

The disease model contends that alcoholism and drug dependence are neither a matter of willpower nor the result of a deeply ingrained habit of recurrent excessive consumption. At the heart of the disease model is the fundamental tenet that alcohol and drug dependence are physical illnesses.

Four identifiers of the disease model

The disease model contends that alcoholism and drug dependence are neither a matter of willpower nor the result of a deeply ingrained habit of recurrent excessive consumption. At the heart of the disease model is the fundamental tenet that alcohol and drug dependence are physical illnesses. The disease model is anchored in the following four identifiers.

1. Primary.
2. Progressive.
3. Chronic.
4. Fatal.

Let's look at each of these identifiers in more detail, beginning with the primary identifier.

Primary

Imagine for a moment, there are no treatment centers for alcoholism and a loved one is an alcoholic. With the lack of treatment facilities, you learn your loved one has only a few options. One is commitment to a locked psychiatric unit with people diagnosed with schizophrenia. Another option is that your loved one's alcoholism will lead to a crime, which could mean time spent in prison. And lastly, your loved one rejects offers to help and slowly sinks into poverty, helplessness, and eventually, homelessness. All of these things would happen because the individual's actions would be considered a voluntary behavioral problem rather than a disease.

Not so long ago, this very scenario played out in the streets and alleys of America. We now recognize alcoholism as a diagnosis all its own, and it doesn't require the presence of another illness to exist. It is independent and can be a primary diagnosis.

Progressive

Perhaps one of the best depictions of the progressive nature of alcoholism in the disease model is E.M. Jellinek's alcohol progression chart. The "Jellinek chart", as it is sometimes referred to as, depicts the spiral of digression for the alcoholic. No matter the socioeconomic background the user originates from, the path of progression remains the same. Some of the more common signs along the progressive path are identified in the table below:

Progressive Defenses	
Denial	Considered the most primitive of all defenses, denial is the patient's refusal to acknowledge the existence of alcohol as a problem in any way in his or her life.
Rationalization	Inventing or justifying drinking habits or behaviors in an attempt to make it appear reasonable or logical.
Projection	There are two types of projection normally associated with alcohol—disowning and assimilation. Disowning: The user attributes unwanted and unacceptable aspects of himself or herself to others, "I'm not like these people." Assimilation: The user assumes everyone else is like him or her in his or her usage etc., "I don't drink anymore than anyone else at the bar."
Conflict minimization and avoidance	Unless intoxicated, most substance dependent people will avoid any interpersonal conflict. As a general rule they do not handle interpersonal conflict well at all, and will often appear passive in group.
All-or-none thinking	Substance dependent people tend to view the world as black or white without any gray area. They are often rigid and will either invest fully in whatever endeavor or not at all.
Self-centered selective attention	This defense mechanism focuses on the fact that the individual is entirely focused on himself or herself. He or she can be extremely resistant to feedback and lack empathy for others.
Obsessional focusing	This obsessional thinking often extends not only to the individual's drug of choice, but also with money, success, sex, etc. This is usually part of a phase to cover for his or her substance dependence.

Chronic

In the disease concept of alcoholism, it is difficult for the dependent user to abstain from using. Even when the patient completes treatment or discontinues usage, the overwhelming urge to return to the substance is chronic. Simply quitting does not eliminate the urge to return. Staying sober becomes a lifelong quest for abstinence.

Fatal

The ultimate outcome for the substance dependent patient is death. On average, an alcoholic lives 12 years less than the non-alcoholic. This doesn't account for accidents, suicides, or homicides attributed to intoxication.

Basic concept of disease model

The patient's loss of control in his or her substance usage is the primary symptom in the disease model. Despite this knowledge the medical community and even some in the treatment community feel that the alcoholism is an acute disease or condition that can be cured. The example of a broken arm is used—once it is set and repaired the medical community feels like the problem is resolved. However, unlike a broken limb the disease of alcoholism is chronic and not curable. Abstinence must be maintained, which is an ongoing struggle for the patient.

Stages of progression symptoms of alcoholism (Jellinek, 1946)

As you learned earlier in this lesson, the concept of alcoholism as a disease has been around for a very long time. Jellinek was extremely instrumental in promoting the disease concept in the last century, specifically with his well known “Jellinek chart” which is still a model today. The four stages of alcoholism are outlined below:

Four Stages of Alcoholism	
Symptomatic Phase	Pre-alcoholic stage characterized by drinking that initially has rewarding aspects. Perceived gregariousness and decreased anxiety are noted as positive attributes during this stage.
Prodromal Phase (Early Stage)	Most notable during this stage is a significant increase in frequency and amount of alcohol consumed. Blackouts are common in this stage as well as drinking to feel normal.
Crucial Phase (Middle Stage)	Involuntary loss of control over drinking is the hallmark of this stage. Unsuccessful attempts to control or stop drinking will occur. Physical demands and withdrawal occur with abstinence. Deterioration of family and social contacts occurs.
Chronic Phase (Late Stage)	The final stage of alcoholism; this stage combines the qualities of the previous three. Collapse of family, occupational, and social status occur. Severe irreversible physical malady or death occurs.

420. Characteristics of obstacles in the disease model

The concept of alcoholism as a disease remains doubtful to some. This is not because they doubt the debilitating toll alcohol takes on the drinker physiologically, psychologically, or socially, but rather because the concept is primarily routed in behavioral traits or attributes verses a deeply ingrained medical disease model concept. Despite the doubts one thing remains certain; there are complications in all spheres of the individual's life including biological, intrapersonal, psychological, and mental health.

There are several characteristics that you must be aware to ensure treatment in the disease model of addiction is successful. We will review each briefly.

Client characteristics

Knowing the target population and the characteristics of your community are important aspects of a successful treatment program. Once you have learned the statistical data regarding the military

community, it is normally universal wherever you are stationed. There are exceptions such as remote assignments or deployed environments.

The active duty military population tends to be more motivated towards treatment than the average civilian community. This is for a variety of reasons including the leverage from commanders, supervisors, and peers. Some may argue that treatment outcomes (as it relates to recidivism) suffer as a result of an individual receiving treatment under duress; however, outcomes do not support that assertion. Civilians are “motivated” towards treatment at times as well; a judge may order treatment in lieu of a jail sentence (failing the program may mean heading to prison) or a spouse may demand an addict go to treatment or they will leave. No matter how the addict gets in to treatment, it will be up to them to start doing the work necessary to get well.

Common questions to ask prior to engaging in treatment should focus on the following topics:

- Education of the patient.
- Family involvement.
- Motivation for treatment.
- Volunteer/command or court ordered.
- Marital status.

There are many more factors which could affect treatment outcomes, but those listed above are generally a core listing. Remember, you should not only be looking for characteristics which may affect patient treatment, but also searching to ensure you are aware of limitations you or your staff may have in providing treatment.

Cumbersome process/resources

There are many reasons why we avoid setting goals—too much time involved, too confusing, too much money, too intimidating, or simply procrastination. All of these are usually considered excuses or obstacles to achieving goals. However, what if some of the feedback I’ve listed is true and not merely excuses? What happens when we, as a clinic, are an obstacle for treatment?

Your program should be easily accessible and provide clear guidance to its participants. Does your program have the visibility it needs to help those in need? Is there clear direction on how to access your program? There are many venues for advertising your program on base (i.e., base newspaper, base cable channel, marquees, pamphlets, fliers, awareness seminars, etc.) and you should become familiar with those as well. You may be asked to assist with some of these events as you gain a greater awareness of the programs offered.

Solicit feedback often from your program participants and be prepared to act on the feedback received.

Lack of support from family/supervisor

As unlikely as it may sound on the surface, you may find the patient’s family and/or chain of command are tepid, at best, in supporting the patient. Often the patient has tried a variety of “escape hatches” to avoid getting into trouble for his or her alcohol use. When the same doubting individuals hear that the patient is suffering from a “disease called alcoholism” (this area is in quotations to emphasis the sarcasm the patient and you may encounter when soliciting support) they may feel the patient is attempting to make more excuses or avoid consequences for his or her behavior.

Many patients have “burned many bridges” and may find it difficult to find anyone in their social or family group who is willing to support them. This will be an obstacle to treatment you may need to account for.

Lack of multidisciplinary team members or investment

In the mental status examination (MSE) section, you learned that you should always ask for help if you feel like you're in over your head. Substance abuse is no different. Many times, patients will arrive with a multitude of problems in addition to substance abuse. As mental health journeymen, financial, spiritual, and legal issues are not our forte, nor should we attempt to provide counseling for topics we are not familiar with or for which we are not credentialed. If you influence a patient in a manner which results in negative consequences (investment advice, legal consultations, etc.), this is unethical and potentially illegal.

Patients often will have a variety of physiological problems associated with the abuse of alcohol. Know the limitations of your staff's credentials and expertise. Ensure you are able to evaluate, accommodate, or treat the needs of the patient prior to engaging in establishing a treatment plan.

421. Characteristics of the biopsychosocial model of addiction

The biopsychosocial model of addiction simply ties many of the other models into one; selecting the best methods from each and adopting them. The premise of the biopsychosocial model is to link various biological, psychological, and sociocultural factors with each of them "weighted" in the sense that each area is considered to be equally responsible for the individual's addiction. By *not* relying on one feature, the subscriber to the biopsychosocial model is free to implement a tailored program that better suits the patient. Clinicians who use this model like the ability to change focus rather than feeling tethered to a specific procedure or model.

General information

This model requires the interviewer to be well versed and comfortable in interviewing techniques that will cover a range of topics to encompass the entire biopsychosocial model. The capstone of the disease model, of course, is the biological/genetic aspect of addiction. The biopsychosocial model believes the biological aspect of addiction is significant; however, it is one of only numerous other contributing factors. The significance of family gene ancestry is important in this model, but only to the extent that other factors are weighed against its contribution to the patient's addiction.

Essential Features

The following table outlines three essential features of the biopsychosocial model you should understand.

Biopsychosocial Essential Features	
Biological	This area of the model focuses on identifying genetically based explanations for a patient's alcohol diagnosis. This will focus primarily on first line blood relatives and then other family members who were known substance abusers or dependent through the use of a genogram.
Psychological	Examining what cognitive factors may have precipitated substance use/abuse will be important (peer pressure, experimentation?). You will also want to explore the patient's past psych history to ascertain if he or she has been dually diagnosed.
Sociocultural	Explore the patient's current social environment. Also, delve into the patient's early childhood, adolescence, and young adulthood as this is perhaps the single most significant impression on his or her developing psyche.

Obstacles in the biopsychosocial model

The biopsychosocial model is widely accepted although not as widely used as the disease model. There appears to be few voiced negative implications or complications with this model that you don't find in any other model. The main obstacle, as with many other models, remains the patient's willingness or unwillingness to change. Other obstacles may come from peers and their acceptance of the Biopsychosocial Model.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

419. Features of the disease model of addiction

1. What criteria encompass the disease model of addiction?
2. Define *addiction*.
3. Define *disease*.
4. What fundamental tenet is at the heart of the disease model?
5. What are the four stages of alcoholism?

420. Characteristics of obstacles in the disease model

1. Why does the military population tend to be more motivated toward receiving treatment for alcoholism than the average civilian?
2. What venues can you use for advertising the substance abuse program on base?

421. Characteristics of the biopsychosocial model of addiction

1. What is the premise behind the biopsychosocial model of addiction?
2. What is the main obstacle in the biopsychosocial model of addiction?

2-2. Pharmacology and Implications of Abused Drugs

Recreational drug use is a misnomer. Drug use is not an activity that society as a whole, and certainly not the military, considers entertaining or recreational. The use of psychoactive substances in America often results in countless unfinished lives lost each year and countless others effected through broken homes, family maltreatment, lost jobs and opportunities.

This lesson will address the broad spectrum of drugs following the 12 classes of substances outlined in the *Diagnostic and Statistical Manual—Fourth Edition—Text Revision* (DSM IV-TR). Some

abused drugs have been around for hundreds of years while others are synthetic or “designer drugs” which are tailored and continue to evolve. The Mental Health Journeyman should continue to educate himself or herself beyond this lesson and stay vigilant for new developments in this area.

422. Pharmacology of abused drugs

This lesson provides an overview of each class of drugs as it relates to the pharmacokinetics; it isn’t intended to be all encompassing. The DSM IV-TR should be used to form a preliminary diagnostic impression of any of these drugs. The following table identifies the basic pharmacology of abused drugs the journeyman will need to study and become knowledgeable.

Drug Name	Street Name	Information
Amphetamines	Speed, Bennies, Black Beauties, White Cross, Hearts, Crystal, Dexies, Eye Openers, Meth, Poor Man’s Cocaine, Ice, Glass	<ul style="list-style-type: none"> • Central nervous system (CNS) stimulant. • Sleeplessness is the hallmark of this substance. • Effects are similar to cocaine, only lasting longer-acting. • Binges referred to as a “speed run” which are followed by intense depression referred to as “crashes.” • “Crashes” are often managed with poly substance usage in an attempt to manage the depression and agitation. • Methamphetamine is the most abused Amphetamine. • Legal medical purposes include treatment of obesity, Attention-Deficit/Hyperactivity Disorder (ADHD), and Narcolepsy.
Inhalants	Laughing Gas, Poppers, Snappers, Pearls, Rush, Bang, Glue, Locker Room, Whiff	<ul style="list-style-type: none"> • CNS depressant. • Widely available in normal household products producing acute and short acting psychoactive effects after inhalation. • Toluene (glue) followed by gasoline are the most popular inhalants. • Quickly absorbed with almost instantaneous effects. • High doses may result in respiratory failure or sudden arrhythmia. • With the exception of anesthetic agents, inhalants have no medical purpose. • Chronic use can result in irreversible brain or liver damage.
Nicotine	Chew, Snuff, cigarettes, smokeless tobacco, spit tobacco	<ul style="list-style-type: none"> • CNS stimulant • It is a fallacy that cigarette smoking enhances mood or decreases stress, in fact it increase blood pressure among other detrimental physiological effects. • Smoking can cause birth defects. • Chronic use of nicotine can cause emphysema, cancer of the lung, throat, mouth, and heart disease.
Caffeine	The Caf, Bathroom Express, Piss Maker, Harry the C	<ul style="list-style-type: none"> • CNS stimulant • Caffeine is the most widely used drug in the world. • Caffeine is known to increase mental alertness and increase metabolism to a point. • Excessive caffeine intake can result in dehydration, insomnia, and gastrointestinal discomfort.
Opioids	Smack, Horse, Junk, Miss Emma, Schoolboy, Shit	<ul style="list-style-type: none"> • CNS depressant. • Opioids are the most prescribed of all medications. • With the exception of Heroin, which has no medical purpose, opioids primary purpose is to relieve pain. • Users enjoy either the sedation, euphoric, or the near state of nirvana that the drug produces. • Extremely high potential for abuse or addiction. • Very dangerous when combined with other CNS depressants

Drug Name	Street Name	Information
Cannabis	Grass, Pot, Weed, Bud, Mary Jane, Dope	<ul style="list-style-type: none"> • Cannabis can have multiple CNS effects including acting as a stimulant, depressant, and hallucinogen. • Despite claims of medical usage for cannabis ranging from Crohn's Disease, acquired immunodeficiency syndrome (AIDS), and multiple sclerosis, it remains illegal and without medical use. • Chronic use can result in upper respiratory problems, difficulty concentrating and memory problems.
Phencyclidine (PCP)	Angel Dust, Hog, Rocket Fuel, Goon, Busy Bee, Crystal Joint, Super Grass, Pinwheel Joint	<ul style="list-style-type: none"> • CNS depressant. • The effects of PCP are highly unpredictable and at times erratic. • PCP on occasion has been known to trigger psychosis. • Deaths related to PCP more often occur from an accident or suicide than from the drug itself. • Long-term effects include short- and long-term memory loss, difficulty concentrating, and depression.
Cocaine	Blow, Nose Candy, Snowball, Tornado, Wicky Stick	<ul style="list-style-type: none"> • Powerful CNS stimulant. • Effects are similar to amphetamines; cocaine's high is shorter in duration (beginning nearly immediately and lasting as long as 40 minutes). • Crack is a form of cocaine obtained by "freebasing." Freebasing is the term used when vapors from the crack are inhaled. • The allure of crack is the intense immediate high lasting from 30 seconds to 1 1/2 minutes, coming down after 10 minutes. Crack is extremely addictive. • Cocaine is well-known for its effect on the cardiovascular system including cardiac arrest, seizures, and death.
Hallucinogens	Acid, Red Dragon, Heavenly Blues, Shrooms, Button, Loaf Drug	<ul style="list-style-type: none"> • Hallucinogens serve no medical purpose. • Lysergic Acid Diethylamide (LSD), a hallucinogen, is the most potent of any psychoactive drug known. • Hallucinogens use alters mood, thought, perception and brain function including illusion, delusions, and hallucinations. • Effects vary on the drug used and the amount of adulteration with other drugs that may occur. • "Flashbacks" can occur and are the result of chronic use of hallucinogens. • An increase in unintentional self-injury as the result of lack of depth perception, lack of judgment or insight, i.e., "I can fly!" results in the individual jumping out a window or the like.
Sedatives, hypnotics, or anxiolytics	None.	<ul style="list-style-type: none"> • CNS depressant. • Intoxication emulates alcohol intoxication. • Medical usage includes treatment for anxiety and as a sleep aid. • Use can cause physiological reactions including inappropriate sexual or aggressive behavior, impaired judgment, and impaired global functioning.

Drug Name	Street Name	Information
Other or Unknown Substances	<p>This area will be used to identify specific drugs that are considered “club drugs” or that are popular at this writing.</p> <p>Methylenedioxymethamphetamine (MDMA)</p> <p>Ecstasy, XTC, E, X, Adam</p>	<ul style="list-style-type: none"> MDMA is a CNS stimulant and considered an amphetamine, but also has hallucinogenic effects. Synthetic (“designer drug”) tailored ingredients by its maker. Promoted as “love drug”; reduces inhibitions, eliminates anxiety, and creates intense tactile stimulation lasting 4–6 hours. Death occurs with its usage primarily as a result of dehydration or heat stroke during or following a ‘rave’ all night dancing. MDMA paraphernalia include pacifiers or suckers to prevent teeth grinding, Vicks Vapor-rub and a facial mask, said to heighten the euphoria of the drug.
	<p>Ketamine</p> <p>K, Special K, Cat Valium</p>	<ul style="list-style-type: none"> Ketamine is a CNS depressant and considered similar to PCP, but also has hallucinogenic effects similar to LSD. Previous medical use as an anesthetic; it is only used by veterinarians as an animal tranquilizer currently. The allure is the short duration of approximately one hour and the dreamy, tranquil, and out-of-body dissociative state experienced by its users. Side effects include depression, amnesia, delirium, difficulty concentrating, and long-term memory loss.
	<p>Gamma Hydroxybutyric Acid (GHB)</p> <p>Liquid Ecstasy, Scoop, Easy, Lay, Goop</p>	<ul style="list-style-type: none"> GHB is a CNS depressant. Original medical purpose as a dietary supplement and muscle enhancer, banned by the Food and Drug Administration (FDA) in 1990. In low doses the user experiences euphoria, talkativeness, affectionate, playful, sensuality, and increased sexual experience. High doses create sedation, difficulty concentrating, and loss of consciousness. Sometimes referred to as a “date rape” drug. Victim is normally sedated and has no recollection of events. Widely abused by adolescence due to its easy accessibility as an over-the-counter (OTC) cold remedy.
	<p>Dextromethorphan (DXM)</p> <p>Robo, Robo-tripping, Tussining</p>	<ul style="list-style-type: none"> DXM is found in over 75 OTC medications including Robitussin, Vicks 44, Drixoral Cough. Users drink the entire bottle to achieve a high similar to PCP and Ketamine. Higher doses result in disorientation, confusion, syncope, and zombie-like “robo-walking.” Overdose can result in a coma or death. Possession is legal, misuse of course is not.

Alcohol

Alcohol is such a socially accepted drug that it is often not even considered a drug by many in society. When patients are asked about drug usage, they never mention alcohol. Normally, you must ask specific questions regarding the use of alcohol. We will look more in depth at this drug as you are more likely to encounter it on a regular basis when assessing patients. The journeyman should use this information as a guide to identify common facts about alcohol and not as an end-all diagnostic tool. Use the DSM IV-TR criteria to confirm a diagnosis.

Alcohol by the numbers

The following information focuses on the substances used to produce the three main types of alcohol and the amount of alcohol content generally found in each type.

Beer

Beer is made from a variety of fermented grains with an alcohol content generally ranging from three to six percent.

Wine

Wine is produced from fermented fruits with an average alcohol content of 11 to 14 percent. Wine coolers and similar drinks contain fruit juice and sugar, which are added, lowering the alcohol content to around four to seven percent. However, fortified wines contain increased amounts of alcohol reaching 18 to 20 percent in some cases.

Liquor

Liquor is made by distilling a fermented product with an alcohol content generally ranging from 40 to 50 percent. The actual alcohol content in liquor is often confused with the degrees of “proof” indicated on the label. In the United States, the degrees of proof are actually twice as high as the alcohol content. For example, 80-proof liquor is actually 40 percent alcohol.

It is well known by now, but worth repeating, that a 12-ounce glass of beer, a 5-ounce glass of wine, and a 1.5-ounce shot of liquor all generally contain the same amount of alcohol, and therefore, have an equal physiological affect on the body.

Knowing how many drinks a person has had is critical in helping us deal with the initial stages of their addiction. While there isn’t a specific number of drinks that should ring a bell in our heads as counselors, we DO have to take into account the amounts they are drinking when trying to decide how to best help them in potential recovery. Think of a time when you’ve gone to a bar and bought “a few drinks.” Chances are, the bartender did not get out a measuring cup and systematically pour the exact amount of alcohol they put into your drink. Variables such as the time of evening, how much you tip, or maybe how you look may impact the amount of liquor you get in your drink. Some people go to a keg party and bring their own plastic cups to pour the beer into. Again, chances are they did not take the time to measure how much of a substance they could pour into their favorite cup. It is sometimes difficult to know how many “drinks” a person had, but getting an accurate count is important, especially when looking at things like tolerance and withdrawal potential.

Physiological signs and symptoms

“My first return of sense or recollections was upon waking in a strange, dismal-looking room, my head aching horribly, pains of a violent nature in every limb, and deadly sickness at the stomach. From the latter I was in some degree relieved by a very copious vomiting. Getting out of bed, I looked out of the only window in the room, but saw nothing but the backs of old houses, from which various miserable emblems of poverty were displayed....At that moment I do not believe in the world there existed a more wretched creature than myself. I passed some moments in a state little short of despair....” This is not a diary entry from an airman at Technical Training at Sheppard AFB, TX. The year was 1768 and William Hickey was describing the morning after a heavy bout of drinking. Alcohol consumption, abuse, or dependence is not a new phenomenon to society nor are the adverse

effects new to the individual, as well as society as a whole. This drug affects every sociodemographic spectrum.

A CNS depressant, alcohol produces feelings of euphoria and relaxation. This is the desired effect its users seek when drinking in moderation. However, when its users increased the amount of alcohol intake over several years it is considered chronic and consequently deadly. Let's examine the toll chronic alcohol use exacts on its users body.

Brain

The effects on the brain can result in temporary or permanent damage. The chronic use of alcohol can result in Korsakoff's Syndrome which is characterized by amnesia. Patients may also confabulate, ramble in their speech, or make up imaginary stories. Wernicke's Encephalopathy is characterized by an unsteady gait, confusion, tremors, atrophy, and difficulty with speech and problems with eye movement. Both of these disorders of the brain are the result of chronic alcohol usage and poor diet. An inadequate amount of thiamin (vitamin B1) is common among alcoholics due to their typically poor diets and chronic alcohol usage. Often these two disorders will appear in tandem diagnostically. The affect chronic alcohol use has on cognitive functioning is normally degenerative over time and often irreversible.

Liver

Most of the alcohol a person consumes is eventually broken down by the liver. Alcohol-induced liver disease (ALD) is a major cause of illness and death in the United States each year. Chronic alcohol use causes three types of progressive liver disease. Fatty liver, the most common form of ALD, is reversible with abstinence. A more serious ALD includes alcoholic hepatitis, characterized by persistent inflammation of the liver. If alcohol consumption continues this condition worsens and progresses to cirrhosis of the liver. Cirrhosis is characterized by permanent scarring of the liver and is fatal. If the liver is extremely inflamed, a provider may be able to push on the outside of the abdomen and feel it, much to the dismay of the patient.

Heart

Much has been said regarding the benefits of alcohol and the heart. However, the benefits are limited to those who may have one drink a day. That doesn't represent the alcoholic's consumption pattern. A well-established complication of chronic alcohol abuse is cardiomyopathy, a degenerative disease of the heart. This is sometimes fatal due to congestive heart failure. Treating cardiomyopathy principally involves the abstinence from alcohol.

Pancreas

The pancreas helps to regulate the body's blood sugar levels by producing insulin. The pancreas also has a role in digesting the food we eat. Chronic heavy alcohol consumption can lead to pancreatitis, or inflammation of the pancreas. This condition is associated with severe abdominal pain and weight loss and progressive death.

Sex hormones

Alcohol interferes with the normal production and maintenance of female and male hormones.

Women

For women this can mean a change in menstrual cycles such that irregular menstruation occurs. This can also result in decreased ability to get pregnant or maintain a viable pregnancy.

Men

For men who use alcohol, the resulting decrease in male hormone levels means a decreased sexual desire, decreased sexual performance, and the development of reactive or absolute impotence over a period of time.

These changes in sex hormone levels for men and women are reversible with abstinence from alcohol and all other mood-altering drugs.

Kidneys

When a person is drinking, the body tends to accumulate water, which increases urinary output. This is not due to disease of the kidneys, but is caused by a change in the hormone aldosterone, which regulates water in the body.

Lungs

The body disposes of alcohol in two ways: *elimination* and *oxidation*. Only about 10% of the alcohol in the body leaves by elimination from the lungs and kidneys. Alcohol causes an increase in the fluid accumulation in the lungs and can lead to chronic lung infections.

Psychological

Alcohol's affects are far more reaching than a mere change in mood or relaxation. Many times patients are drinking to avoid some psychological pain, depression, anxiety, guilt, etc. Furthermore, it is a rare occasion when the patient will come in on his or her free will and admit to an alcohol problem. Normally they are identified as the result of an alcohol incident, or the result of their negative behavior. The patient often suffers quietly at times questioning his or her own usage and just like in the cycle of abuse, promises himself or herself or his or her family "I won't drink like that again" or "I'll cut down" only to end up in the same drinking pattern soon thereafter. This cycle is often as confusing to the patient as it is to those around him or her. Dual diagnosis is common among those diagnosed with alcohol dependence and often creates a dual treatment approach as each needs to be addressed separately.

Social

Aside from the monetary and possible professional costs of job loss, professional licensing loss, loss of credentials, etc., the loss of social status is inevitable for the chronic alcoholic. Sure, some people are hilarious when they're intoxicated and are often the "life" of the party. But, when it's every day or every party and it's the same person, it tends to not be so funny and is more of a sad commentary in the alcoholic's search for approval. "People like me; therefore, I must not be that bad." It's not just that the alcoholic is affecting himself or herself and no one else as he or she often proclaims; many times there is the loss of a family unit and the loss of a productive member of the community.

On average, more than 100,000 Americans will die this year as a direct result of behavior associated with drinking alcohol. This includes automobile accidents, diseases associated with chronic alcohol use, accidental falls and injuries, homicides, and suicides while under the influence of alcohol.

423. Chemically dependent families

Our understanding of dysfunctional families is often based on empirical data that often seems rather statistical and without emotion. The chemically dependent family is very unique in respect to the term dysfunctional family as a whole. The entire family unit is transformed to take on unique roles which compliment the alcoholic's lifestyle. Failure to fulfill the prescribed role is often consequential not only for the "offending" family member, but the entire family unit will suffer the wrath of the alcoholic. Codependency is the term used to describe this unique role each family member plays in the alcoholic's family.

Characteristics of the chemically addicted family

The unpredictable and chaotic lifestyle of the alcoholic is far more reaching than just the antics routinely played out by the addict. Each family member begins to assume a greater responsibility for the alcoholic's behavior. The child believes he or she is to blame for mom or dad's drinking. He or she begins to believe it is by some act of his or her own that causes his or her parent to drink. This futile struggle for some sense of control will be repeatedly played out as long as the alcoholic

continues to drink. The spouse continually provides excuses and alibis for his or her partner's behavior. Unfortunately, codependency becomes as much a part of the problem as the problem itself. Some may believe the term codependency is limited to the family. That will be our focus here, but keep in mind; it is much further reaching than that. It is estimated that an alcoholic's behavior creates at least 10 codependents. This includes employers who turn the other way when the alcoholic's productivity is down or arrives late for work, the babysitter who doesn't confront the alcoholic after tending to the alcoholic's children all night because he or she was too intoxicated to pick them up, and friends who fail to confront the alcoholic after he or she backs out on commitments. Everyone "feeds this monster" and everyone recognizes that failing to "feed the monster" will result in scorn, ridicule, and outright anger towards the "offender."

Roles

Each family member begins to assume a unique role in the home. This is not unique to homes of alcoholics, each of us have a unique role in our families; however, the roles assumed in alcoholic homes are dysfunctional and designed solely to benefit and compliment the alcoholic's behavior. This is more of a survival role than one they would have been given naturally. The dynamics of the alcoholic family are so engrained that children will carry their learned behaviors from adolescence into adulthood as they begin forming relationships of their own. Lack of trust, emotional distance, and the need to be in control of everything at all times often spell doom for their relationships. To reiterate the first paragraph of this lesson, the effects of alcoholism is not limited to the drinker alone; all family members must confront the alcoholism and their own codependent behavior. The following describes common roles often assumed by family members in an alcoholic family.

Chemically Dependent Family Roles	
Hero	<p>The hero is often the individual whose accomplishments compensate for the alcoholic's behavior. This child has two very distinctive behaviors; that of overachiever and caretaker. This child excels in academics, athletics, music or theatre. His or her deeds assure the family that they are defined by more than alcohol.</p> <p>Purpose: The hero role raises the esteem of the family.</p> <p>Negative Consequence: The hero does not receive attention for anything besides an achievement; therefore, inner needs are not met. He or she loses the ability to feel satisfied by whatever feat he or she may have accomplished.</p>
Caretaker	<p>The caretaker is usually a role a parent accepts. He or she tends to everyone's need in the family and is the one trying to "fix" everything. A caretaker loses his or her sense of self in tasks of a domestic nature. Multigenerational alcoholic families will sometimes designate a child in this role, a sign of more serious pathology.</p> <p>Purpose: The caretaker's purpose is to maintain appropriate appearances to the outside world.</p> <p>Negative Consequence: The caretaker never takes the time to assess his or her own needs and feelings. Others cannot bond with the caretaker due to the bustle of activity.</p>
Scapegoat	<p>The family assigns all ills to the person who assumes an unenviable role. The scapegoat often is the focus of not only the alcoholic's furor, but also the family's disdain as he or she is usually deemed the troublemaker. For example, they may tell this person that, "Mom would not drink so much if you were not always in trouble." The child has issues with authority figures as well as negative consequences with the law, school, and home.</p> <p>Purpose: The scapegoat puts the focus away from alcohol; thereby allowing the alcoholic to continue drinking. This role may seem strange in purpose. However, if there were no scapegoat, all other roles would dismantle.</p> <p>Negative Consequence: Alcohol is not identified as an issue. Often, the scapegoat is identified as "The Problem."</p>
Joker/mascot	<p>Often this child is named a class clown in school. The individual is usually the most popular in the family.</p> <p>Purpose: To provide levity to the family.</p> <p>Negative Consequence: The laughter prevents healing rather than produces it. In addition, the mascot frequently demonstrates poor timing for the comic relief.</p>

Chemically Dependent Family Roles	
Lost child	<p>As the title suggests, the lost child disappears from the activity of the family. Favorite places for the lost child are in front of the T.V. as well as in his or her room. This is often the youngest child in the family. Due to the sedentary lifestyle, a lost child will sometimes have issues with weight.</p> <p>Purpose: A lost child does not place added demands on the family system. He or she is low maintenance.</p> <p>Negative Consequence: The lost child sees much more than is vocalized. The family reduces its depth in not listening to what the lost child thinks and feels.</p>

Common family destructive traits

To begin with, let's identify some core beliefs that are inherent in any alcoholic family.

Alcoholics will always maintain these two core beliefs and repeat them to their families:

1. I am not an alcoholic.
2. I can control my drinking.

Similarly, their families have two core beliefs as well:

1. There is no alcoholic in the family.
2. We shouldn't talk about the drinking.

The common family destructive traits are evident to others as well. It's been said; if you've ever wanted to meet the "perfect" child go to the home of an alcoholic. This child, particularly before adolescence, is typically the most accommodating, well-mannered child in the neighborhood. Why? There is the constant fear of saying something to upset his or her drinking parent, which might "make" him or her drink. He or she easily accepts blame in an argument to keep anyone from getting angry. He or she works very hard in school and other activities, leaving little time for himself or herself. In addition to the roles each family member assumes identified above all chemically dependent families have common traits that mirror one another. We will examine these below:

Denial

Denial is the common denominator in every chemically dependent family. Chemically dependent parents deny their addictions and their children are encouraged to cover it up and to deny it too. This is how the roles, discussed earlier in this unit, are established. They grew up learning that the family did not talk about its problems. The family did not deal with feelings either; therefore, individuals may not have learned how to deal with them either.

Denial is not exactly lying. Denial is a defense mechanism that protects us from dealing with a certain reality. If I don't WANT to believe that I am an alcoholic, but I drink 12 12-ounce beers every night, I may minimize the amount I drink in my own head. You, as the counselor, may ask me, "How many beers did you have last night?" I might respond that I "only had about 6" because that is what I really DO want to remember, because in my own head I might associate drinking an entire 12-pack as being bad. It might take interviewing my spouse who could show you all 12 cans sitting in the garage to open my eyes from my own denial.

While driving around town with her two children, the mother might unconsciously use denial to justify her use of methamphetamine. She might say that she didn't use "that much" of the drug to impair her driving. The reality is if she thought about how much she was really using it would affect the way she looked at herself as a person and a mother. Denial is very effective when someone is dealing with addiction because it helps the person feel like he or she is not a bad person.

Denial doesn't work just for the addict; it works for the family as well. Not many husbands, wives, or children would have a smile on their face while leaving the house thinking "Gosh, I'm so lucky to have an addict for a family member." It might start to affect their self esteem. So, it's easier for a husband to say to himself, 'wow, my wife really does work hard and they aren't fair to her at work;

no wonder she needs to relax with a drink from time to time.” This rationalization helps the family member’s self esteem remain intact and denies the addict’s own addiction.

Guilt

Children get the message that they are responsible for the behavior of their alcoholic parent. They feel the blame for their family’s pain, and that it is in their power to control what happens in their family. The guilt over their inability to control the family will stop only when they drop the notion they are responsible for it. Children need to experience their own feelings, and not feel guilty about having feelings, whether they are anger, sorrow, shame, or happiness.

Fear of anger

As children in alcoholic families grow up, they often have difficulty in expressing what they want in relationships. They’ve never learned that they can express anger without losing a relationship or making people uncontrollably upset. Children need to understand that their frustration or anger did not cause mom or dad to drink or use drugs—it was their parent’s own problems and insecurities. Likewise, children need to understand that expressing their own needs and anger in other relationships will not turn their friends to drugs or alcohol. In a healthy relationship, people can talk about their wants and needs; they can work together to find workable solutions to their problems. This problem often carries over into relationships well into adulthood for children of alcoholics.

Relationships

Young adults often become involved with people who are cold and unfeeling because their chemically dependent parent was unable to respond to their emotional needs so they are unfamiliar with anything else. Adolescents growing up with an addicted parent tend to form over-involved, enmeshed relationships, often with (would you believe it?) chemically dependent peers. Very often they have alcohol and other drug problems themselves.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

422. Pharmacology of abused drugs

1. What is the most abused amphetamine?
2. Deaths related to PCP are often related to what event?
3. What is the allure of crack cocaine?
4. What drug’s intoxicating effects emulate alcohol?
5. What well-established complication of the heart is the result of chronic alcohol abuse?
6. What effect does alcohol have on the alcohol abusers lungs?

423. Chemically dependent families

1. Identify the chemically dependent family roles.
2. What two core beliefs do alcoholics have?
3. What two core beliefs does the family of an alcoholic maintain?

Answers to Self-Test Questions**419**

1. Loss of control over the use of the substance and continued use despite negative consequences.
2. Compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal.
3. A condition of the living animal or plant body or of its parts that impairs.
4. Alcohol and drug dependence are physical illnesses.
5. Symptomatic Phase, Prodromal Phase, Crucial Phase, Chronic Phase.

420

1. The leverage of commanders, supervisors, and peers.
2. Base paper, base cable channel, marquees, pamphlets, fliers, awareness seminars, etc.

421

1. To link various biological, psychological, and sociocultural factors with each of them “weighted” in the sense that each area is considered to be equally responsible for the individual’s addiction.
2. The patient’s willingness or unwillingness to change.

422

1. Methamphetamine.
2. An accident or suicide rather than from the drug itself.
3. The intense immediate high, which lasts from 30 seconds to 1½ minutes, coming down after 10 minutes.
4. Sedatives, hypnotics, or anxiolytics.
5. Cardiomyopathy, a degenerative disease of the heart.
6. Alcohol causes an increase in the fluid accumulation in the lungs and can lead to chronic lung infections.

423

1. Hero, caretaker, scapegoat, joker/mascot, lost child.
2. I am not an alcoholic. I can control my drinking.
3. There is no alcoholic in the family. We shouldn’t talk about the drinking.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

38. (419) Which of the following is *not* an identifier for the disease model?
- a. Primary.
 - b. Chronic.
 - c. Crucial.
 - d. Fatal.
39. (419) According to the “Jellinek Chart” regarding progressive defenses, what is the *most* primal of all defenses?
- a. Denial.
 - b. Projection.
 - c. Rationalization.
 - d. Conflict minimization.
40. (419) According to the “Jellinek Chart” regarding progressive defenses, in which type of *projection* does the user attribute unwanted and unacceptable aspects of themselves to others?
- a. Disowning.
 - b. Assimilation.
 - c. Rationalization.
 - d. Obsessional focusing.
41. (419) During which stage of alcoholism is there a significant increase in frequency and amount of alcohol consumed?
- a. Symptomatic.
 - b. Prodromal.
 - c. Chronic.
 - d. Crucial.
42. (420) When a patient “burns bridges” what obstacle to treatment have they likely lost?
- a. Lack of multidisciplinary team investment.
 - b. Lack of support from family.
 - c. Cumbersome resources.
 - d. Cumbersome process.
43. (420) It is considered unethical or illegal for Mental Health Journeymen to provide counseling for all of the following *except*
- a. financial.
 - b. parental.
 - c. spiritual.
 - d. legal.
44. (421) What area of the biopsychosocial essential features explores the cognitive factors which may have precipitated substance use/abuse?
- a. Psychological.
 - b. Sociocultural.
 - c. Biological.
 - d. Spiritual.

45. (422) The legal medical purpose for amphetamines includes treatment for all of the following *except*
- a. obesity.
 - b. depression.
 - c. narcolepsy.
 - d. ADHD.
46. (422) What effects do inhalants have on the CNS?
- a. Stimulant.
 - b. Anesthetic.
 - c. Depressant.
 - d. Hallucinogen.
47. (422) What is sometimes referred to as the “date rape” drug?
- a. MDMA.
 - b. GHB.
 - c. DXM.
 - d. Ketamine.
48. (422) What is the *most* common form of alcohol-induced liver disease?
- a. Cirrhosis.
 - b. Fatty liver.
 - c. Inflamed liver.
 - d. Alcoholic hepatitis.
49. (423) Which chemically dependent family member’s role is to maintain appropriate appearances to the outside world?
- a. Hero.
 - b. Caretaker.
 - c. Scapegoat.
 - d. Joker/mascot.
50. (423) What is the common denominator in every chemically dependent family?
- a. Guilt.
 - b. Denial.
 - c. Anxiety.
 - d. Strained relationships.

Please read the unit menu for unit 3 and continue ➡

Unit 3. Psychometric Assessments

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PSYCHOLOGICAL TESTS, often referred to as psychometrics or psychometric examinations, are standardized sets of procedures or tasks used to obtain a sample of behavior. A person's responses to the test questions are compared with those of a control group. This comparison allows the psychologist to make inferences about the person's psychological characteristics. Some common characteristics that are often evaluated include intelligence, motivation, personality, values, levels of depression or anxiety, and coping patterns.

3–1. Testing Principles

Psychological tests are often used in assessments that can compliment a diagnosis or as part of treatment planning. Even though psychological tests are considered more precise and reliable than interviews and other types of evaluations, they are less than perfect. The reliability of a test is dependent on the skills of the examiner and the competence of the psychologist who interprets the results. Therefore, to properly use this important tool, you need to know how to administer testing. The first step in understanding and using psychological testing focuses on knowing how tests are designed. In this unit, we look at basic testing terms, test construction, and administration.

424. Administrative concepts of testing measurement

As stated earlier, a psychological test is defined as a standardized objective measure of a sample of behavior. What do we mean by the term standardized? First, it means that the test directions and questions used to evoke patient responses are always presented in the same manner. Second, it means that a norming or comparison group has been pre-tested so scores obtained by a patient are compared to the norm group. If testing scores obtained by different individuals are to be compared, testing conditions must be the same or universal for everyone. This means, you, as the test administer, must be thoroughly familiar with directions for any test you administer. This uniformity of procedure requires that you clearly understand the nature of the test, materials used, time limits, and oral instructions. In addition you need to know how to demonstrate the test and the ways to handle inquiries from the patient. You should be on guard for complacency. Once you have mastered the administration of these tests, confidence can turn to complacency and your actions can compromise the test outcome.

In psychological testing terms, objectivity means that the administration, scoring, and interpretation of test scores are not dependent on the subjective judgment of the test examiner. Compare this to your test scores in the Weighted Airman Promotion System (WAPS). Sure, your Enlisted Performance Reports (EPR) are based on subjective judgment, but your test scores are objective. You're the only person who can affect the score.

The objective evaluation of psychological tests involves not only standardization—validity and reliability are also important considerations.

Validity

One of the most important concepts of testing measurement is validity, i.e., a direct check on how well a test does what it is designed to do. A test designed to measure intelligence is of no use if it cannot perform that function. A test is said to be valid if it actually measures what it proposes to measure. Validity is usually proven through independent, external criteria for whatever the test is designed to measure. For example, the military uses an aptitude test in selecting future airmen. Their future success in the Air Force is the external criteria. If a certain number of airmen have successful careers, then the test is valid—the test is doing what it's supposed to do.

Reliability

A reliable test yields consistent measures. This simply means there is a consistency of scores obtained by an individual when re-tested with the same test on different occasions, or with different groups of similar items. Your responsibility as test examiner is to maintain uniform testing procedures and to control time limits, inquiries, instructions, and the testing environment—thereby reducing the possible error factors and making the test scores more reliable.

Psychological testing administration

Each psychological test has specific instructions as to how it should be administered, scored, recorded, and interpreted. The clinical psychologist is the only care provider specifically trained in selecting, interpreting, and providing supervision of psychological tests. The psychologist decides which tests are to be administered based on the presenting problem, needs of the patient, and time limits. However, some basic rules and considerations apply to all psychological tests.

Qualified test examiner

How would you feel if you were being interviewed for a job and found out that the person interviewing you knew very little about the position or requirements of the job? The same considerations can be applied to a test examiner who knows little about the test he or she is administering to patients. You must be thoroughly familiar with the standard instructions if the test scores you obtain are to be used in comparison with the normative population. Also, a test administered or scored incorrectly is useless to the psychologist and the patient. Always have another staff member look over your scoring of a completed test, especially in your early formative learning experience as a Mental Health Journeyman. Even if you have given the Weschler Adult Intelligence Scale-Revised (WAIS-III) 200 times, and can recite each page from memory, use the manual. The importance of standardized instructions cannot be overstated. Procedures must be uniform for testing to be valid and reliable. Becoming a qualified test examiner takes time and a lot of practice. Training and practice will be essential beginning with reviewing the material and then sitting in with a staff member experienced in psychometrics as an observer. Ensure that you have enough training to deal with just about any contingency that may arise in the testing environment. The proper interpretation of test scores relies heavily on a thorough understanding of the test, the test taker, and testing conditions.

Testing conditions

The testing environment should be free from interference. Any outside noises or distractions can compete with the test for the patient's attention. The room selected for psychological testing should be well-ventilated, well-lighted, and quiet. A room away from normal traffic of the clinic or that has soundproof walls is ideal for this purpose. Post a sign on the door and inform staff members not to interrupt when testing is in session. Loud noises, poor lighting, and frequent interruptions can have a negative effect on testing scores. If possible, testing material should be laid out prior to the testing session to allow minimal searching and ensure you are prepared. It's a good idea to place the material on a table within your reach, but not so close as to cause a distraction to the patient.

Test security

An intelligence test would have little value if everyone knew the answers to the test. Psychological tests must be maintained in a secure place, preferably a locked cabinet. Test security means more than just locking them up. You must be careful *not* to allow more practice than necessary when administering a test, because practice may elevate the patient's score. Test security also means *not* discussing the different tests answers or test results with those who don't have a need to know. This is considered a test compromise. Much of the data obtained in the testing situation is of a highly personal nature. Patients consent to these procedures with hopes that the information will lead to resolving their conflicts. Therefore, common sense and ethics dictate that this information should only be shared with the psychologist evaluating the test data.

Establishing rapport

Rapport is the harmonious relationship between an examiner and a patient. Your patient must feel at ease with you and have an understanding of what is about to take place. If you show a genuine interest in and acceptance of the patient, he or she is likely to feel comfortable. Usually, this can be done by investigating your patient's needs and limitations. Simply ask him or her about the need to wear glasses or a hearing aid. If your patient appears tired or sleepy, inquire about his or her sleeping habits or whether he or she worked the night before. All of these things relay to the patient your concern for his or her well-being. However, as with most things, rapport is not something that can be assumed once it's established; relationships are maintained at an expense of effort. Efforts that you use to establish rapport should always be documented in your observations of the patient's behavior.

Observing and reporting behavior

Once you have established rapport and the patient is relatively at ease, you can begin testing. As stated earlier, you must be thoroughly familiar with the testing materials and procedures so that you can administer the test with ease and professionalism. This is important for two basic reasons. First, your attention should *not* be so focused on the procedures that you miss behavior exhibited by the patient. This information is valuable in the psychologist's evaluation of the testing and subsequent reports. Second, any inept behavior exhibited by you may cause the patient to doubt your ability to evaluate him or her objectively, which may increase the anxiety level of the patient. Sometimes, the patient's behavior in a testing session can provide you with more information than the test. Any behavior or miscues by you, the test examiner, should be noted. This can invalidate test material and influence the patient's outcome for a positive or negative result.

Elicited behavior

Elicited behavior occurs in response to a specific test question. While the patient is responding to test questions presented orally, you must copy down the response verbatim. The reason for this is that two answers might earn identical scores in a test, but may have a qualitative difference. For example, a comprehension test might have the following item: "Why do people need a driver's license to drive a vehicle?" The response, "To generate funds for highways" is quite different from "To ensure people understand the basic rules and safety procedures of operating a vehicle." As you can see, the scoring of verbal responses is often a complicated procedure requiring careful judgment by you, the examiner. Therefore, you can see why it's so important that you write down all responses. The verbatim recording of verbal responses permits the psychologist and you to verify that the correct numerical score is given.

Sometimes there is not enough room on the scoring sheet to completely record all answers. This limitation can be overcome by having a note pad kept for behavioral notes. As you proceed through the testing session, you can label the note pad to indicate which test the patient is working on and record the lengthy responses. Labeling the note pad in this manner also provides a record of the order in which the tests were given and shows at what point during the session various recorded behaviors occurred. You should also record the way in which a patient approaches a non-verbal task. For

example: Is it a logical or analytical procedure, or did the patient just kind of stumble around to complete the task? Again, just as important as the score is the way the patient finds the answer.

Spontaneous behavior

Spontaneous behaviors occur more or less freely, and independently of the response required or demanded by a test question or task. Each patient engages in spontaneous behaviors almost constantly, and these can be divided into two areas:

- Behaviors that reveal mood, emotion, or personality traits.
- Behaviors that may have a direct relationship to test performance.

Mood, emotion, or personality traits

The patient's subjective state will have a bearing on how the testing can be interpreted. If, for example, the psychologist sees signs of depression in the test data, and you report that the patient presented a sad and downcast appearance, this would help to corroborate the test findings. Also, some behaviors arising from the relationship between you and the patient can reveal the patient's characteristic mode of relating to others. Some patients express a wide range of behavioral traits during the testing session. All such behavioral patterns should be carefully noted and recorded for inclusion in the test findings.

Behavior and relationship to test performance

Certain behaviors may suggest attitudes toward testing that might have a relationship to test performance. A patient might demonstrate hostility, suspicion, nervousness, fear, or indifference toward the testing situation to a degree that could affect the meaning of the test data. This information is essential to the psychologist, if the test data is to be properly evaluated. Unfortunately, not all behaviors that affect the patient's performance are easily recognizable. However, you must learn to recognize behaviors that might have an effect. Any extremes or exaggerations in emotional or personality trait behaviors might have a significant effect in test performance to the point of invalidating the entire test.

425. Recording testing sessions and handling problem situations

Psychological tests should be scored after the testing session as the event is still fresh in your mind and your full attention must be given to administering the test and observing patient behavior. Decisions of great importance to the patient are made on the basis of test scores. For this reason, you must ensure that tests are scored accurately. An inaccurate score will lead to incorrect interpretations with implications for the patient. The procedures for scoring each test are contained in the manual of directions for that test. The scoring procedures, like the directions for administration, must be followed exactly. After the tests are scored, your next step is to coordinate your behavioral observations. As a minimum, your report should contain a record of problem situations and any incidents that threatened to, or actually did, render any test data invalid, and the corrective measures taken.

Formatting test reports

There are many ways the report can be formatted. However, in this lesson, we will discuss the two widely used formats.

Temporal format

In the temporal format, the testing session is reported as it occurs, test by test. This is the simplest format and the one a new Mental Health Journeyman should use. However, it's the least convenient for psychologists, since they must search through the whole report to find behaviors that corroborate test scores.

Topical format

The topical format is often used by the more experienced Mental Health Journeyman/Craftsman. In this format, sections of the report cover various topics. For example, a section on testing would describe the tests used, order in which they were administered, problems encountered, remedial action taken, and any other specific information about the mechanics of testing. A section could also be devoted to mood, emotional, and personality characteristics. A section on unusual behaviors would include a summary of all unusual behaviors observed during the testing session. A section on factors influencing the test could include:

- Previous testing experience.
- English as a second language.
- Diverse cultural backgrounds.

Finally, there should be a section that rates the degree of cooperativeness which the patient exhibited during the testing session.

Handling problem situations

Now you have some idea of how busy you will be in a testing session. You must manipulate testing materials, operate a stopwatch, record responses, and observe and record the patient's behaviors. You must also wear another hat—that of a troubleshooter. This means you must be able to recognize a problem that could invalidate test data and be able to resolve that situation.

Invalid testing information

Various psychometric tests make an allowance for spoiled test items or subtests. Spoiled items are those items that are invalid either through an error in administration or some interruption or distraction during testing. If an entire test or subtest is invalidated by spoiled items, you should document the incident and let the psychologist decide whether the data is useful or if testing will have to be redone. A good example of this is a patient who is interrupted by a loud noise while trying to recall a series of numbers on the WAIS-III test. After being distracted, the patient is unable to remember the numbers. This becomes a problem because the standardized procedures call for uninterrupted trials for each series. In this situation, you would go ahead and administer the remainder of the subtest for qualitative information, but not for scoring purposes. You would mark the subtest “spoiled” and prorate (average) the missing subtest score according to directions in the manual.

Patient fatigue

Depending on the testing battery and the abilities of the patient, a testing session can last from several hours to several days. You must be alert for signs of fatigue in the patient. When signs are noted, give the patient a break. Breaks are permissible and should be given between tests in a large battery and sometimes between subtests of a large test. It's a good idea to use the breaks to maintain rapport with the patient. If, after many hours of testing, the patient fails to be refreshed by a break, it's often best to finish testing at a later date.

Difficult patients

Sometimes you have patients who, because of hostility, impulsivity, and neurological or physical impairment, are difficult to test. A hostile patient often poses problems in establishing rapport. If you can deal effectively with the hostility, then the patient can often be tested. Constantly direct the impulsive patient's attention toward the task. Neurological patients often have difficulty with completing items within the prescribed time and/or understanding complex problems. Patience and understanding of the patient's deficits can help you in dealing with these individuals. Physically handicapped patients may pose problems because of their physical limitations. Again, patience and understanding of the limitations will help you in maintaining rapport and completing the testing session.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

424. Administrative concepts of testing measurement

1. What does the term *standardized* mean as it relates to psychological test measurement?
2. What does the term *objectivity* mean as it relates to psychological test measurement?
3. What is the purpose of maintaining uniform testing procedures?
4. Name two reasons why you should be familiar with the testing material and administer the test with ease and professionalism?

425. Recording testing sessions and handling problem situations

1. Which testing format is the least convenient for psychologists and why?
2. What test responses are considered spoiled items?

3-2. Administration of Specific Psychological Tests

Thousands of psychometric tools have been created throughout the development of the field of psychology over the years and serve many different purposes. Some focus primarily on intelligence and others examine specific cognitive functioning including moods and habits. While all differ as far as validity and reliability are concerned, a few mainstream tools are commonplace in any clinic. This section will provide not only a description of these inventories, but rules on backgrounds, administration, and scoring. Although there is always a chance that one might never administer all of these in their career, a general knowledge of these will aid in understanding some of the tools used to aid in the therapy of a patient.

Ethics warrant high regard with consideration of psychometrics (psychological testing).

Administration of the Minnesota Multiphasic Personality Inventory (MMPI)-II must be carried out in a way that guarantees the subject's privacy, freedom from distraction, and freedom from intrusions. There must be full assurance for the patient that the test results will be respected, protected, and used for the benefit and enhancement of the subject's welfare. Of high ethical consideration is also the provision of supervision by a fully qualified professional (psychologist) for the test administrator.

426. Beck psychological inventories

Aaron Beck is an American psychiatrist who was one of the first to use cognitive therapy. Beck also created a few psychological inventories as quick "self-report" inventories that could be given out in individual or group situations to allow a provider to get a snap shot of how a client was doing in

relation to depression, hopelessness, and suicidality. We will discuss Beck's anxiety and depression inventories.

Beck Anxiety Inventory

The Beck Anxiety Inventory (BAI) was developed by Aaron T. Beck to measure the level of anxiety in adults and adolescents. The BAI is suitable for patients 17 years of age and older. If asked as to the purpose of the test, inform the patient that it is to help measure how he or she is feeling.

Administration

The BAI is perhaps one of the simplest inventories to administer. The BAI is a one-page self-report inventory, but it can also be read aloud to the patient. It consists of 21 various items that are scaled from 0 to 3. The patient should rate the different items as he or she has felt within the past week including the date the BAI is administered. The patient should answer each question with only one response. The testing should take approximately 5 to 10 minutes.

Scoring

Scoring the BAI is fairly simple. Add together the scores as follows:

Not at All - 0

Mildly - 1

Moderately - 2

Severely - 3

These scores should not exceed 63 points. Totals should be placed on the bottom right of the answer sheet. For any blank items or multiple answers for one item, either clarify the items with the patient or consult a provider.

Beck Depression Inventory II

The Beck Depression Inventory (BDI)-II is another Aaron T. Beck inventory that follows a format similar to the BAI; however, the primary focus is on depression. The BDI-II is suitable for those patients over the age of 13 years and measures the severity of depression as categorized by the DSM IV-TR.

Administration

The BDI-II is also a relatively simple inventory to administer. The BDI-II is a two-page self-report inventory, but it can also be read aloud to the patient. It also consists of 21 various items that are scaled from 0 to 3. A subtle but important difference is that the patient should rate the different items as he or she has felt within the past two weeks. The patient should answer each question with only one response. The testing should take approximately 5 to 10 minutes.

Scoring

Scoring the BDI-II is fairly simple. Add together the scores as they are numbered on the inventory, writing in the subtotals and the total at the bottom of the page where it is specified. These scores should not exceed 63 points. For any items left blank or have multiple answers for one test item, either clarify the items with the patient or consult a provider.

427. Millon Clinical Multiaxial Inventory-III

Primarily designed by Theodore Millon, PhD, the Millon Clinical Multiaxial Inventory-III (MCMI-III) is a popular inventory used to help diagnose personality disorders and clinical syndromes. Structured to complement the criteria in the DSM IV-TR, the MCMI-III offers results and interpretations of a patient's answers. The MCMI-III is primarily designed for those who show signs of psychological abnormality, and should not be used for those without mental illness. The MCMI-III is to be administered to patients older than 18 years of age. If asked as to the purpose of the test,

inform the patient that it is to assist the provider in getting to know the patient, or help the provider in better assisting the patient with his or her current situation.

Clinical scales

The MCMI-III contains 30 different scales that are used for diagnoses. You should familiarize yourself with their characteristics and how it will assist in the treatment planning of patients.

Clinical Personality Pattern Scales	
The scales in this area are reflective of the corresponding DSM IV-TR personality disorders. A high score (above T=85) is indicative of traits complimentary of the DSM IV-TR and should be explored further. This chart provides an overview of primary characteristics of the disorders and is not all encompassing.	
Scale	Clinical Meaning of Scales
Scale 1: Schizoid	Patients who score high in this area often demonstrate the following schizoid personality disorder traits; apathy, listless, distant, asocial, difficulty experiencing any range of emotion including pleasure or pain. Often viewed as detached from others and have difficulty forming relationships.
Scale 2A: Avoidant	Patients scoring high in this area often demonstrate the following avoidant personality disorder traits; avoidance of relationships in an effort to avoid being emotionally hurt, on guard to avoid letting their feelings be known, fearful, and mistrustful of others' intentions.
Scale 2B: Depressive	Patients scoring high in this area demonstrate a depressive personality type that includes a permanent feeling of life without pleasure, viewing life with constant pessimism, and hopelessness.
Scale 3: Dependent	High scores on this scale are often representative of individuals who are often very comfortable in submissive, passive, and insecure roles in life. They often lean on others for support, nurturing, security, and affection.
Scale 4: Histrionic	High scores on this scale are often representative of individuals who are often very gregarious, flirtatious, constantly seeking attention, approval or affection, socially cunning, and confident. This outward confidence is often guise for the need to be accepted and needed.
Scale 5: Narcissistic	High scores on this scale are often representative of individuals who are often considered arrogant, overly self-confident and demonstrate their alleged superiority over others via manipulation, consistently seeks approval of themselves from others which in-turn results in an overvaluation of self.
Scale 6B: Aggressive (sadistic)	High scores on this scale are often representative of individuals who seek gratification from the humiliation or suffering of others. They tend to be very aggressive, combative, abusive, and brutal in their behavior while cloaking it in a socially grounded rationale.
Scale 7: Compulsive	High scores on this scale are often representative of individuals who are considered very self-restrained and disciplined. They tend to be prudent, perfectionistic, and controlled in their behavior.
Scale 8A: Passive- aggressive	High scores on this scale are often representative of individuals who often struggle with being complacent and accommodating others and then vacillating to being focused and driven. Similarly they often display erratic behavior with angry outbursts followed by periods of remorse and pity.
Scale 8B: Self-defeating	High scores on this scale are often representative of the individuals who seemingly sabotages their own efforts and exploits their misfortune as evidence of their inability to experience goodness in their lives. They will often present themselves in an inferior position purposefully.

Severe Personality Pathology Scales	
Scale	Clinical Meaning of Scales
Scale S: Schizotypal	Individuals scoring high on this scale are often perceived as odd, strange, cognitively eccentric, and socially detached from others. The individual may appear suspicious and wary of others or withdrawn with a flat affect.
Scale C: Borderline	High scores on this scale are often representative of an individual with intense emotional feelings of apathy, fears of abandonment, interspersed with intense anger, anxiety, and euphoria. Chaotic unfulfilled commitments and relationships filled with over idealization followed by devaluation are often common.
Scale P: Paranoid	High scores on this scale are often representative of individuals who are defensive against perceived criticism and deception. They maintain a near vigilant stance and mistrust others and their motives. They fear losing their independence and are fiercely opposed to any amount of control that may be exerted over them.
Clinical Syndrome Scales	
Scale	Clinical Meaning of Scales
Scale A: Anxiety	Individuals scoring high here often appear with nonspecific phobias, somatic complaints, tension, indecisiveness, and an inability to relax. Often the patient will not be able to explain what precipitated the feelings of anxiety, but they are very real for the patient.
Scale H: Somatoform	Individuals scoring high in this area often complain of somatic complaints that are exacerbated by psychological difficulties (stressors, etc.). Often the complaints are nonspecific and without medical evidence of an injury or illness. When a medical condition does exist, it is often dramatically embellished despite reassurances otherwise.
Scale N: Bipolar: manic	Individuals scoring high on this scale are considered overly active, impulsive, and easily distracted. They have unrealistic goals and expectations of themselves, rapidly shifting moods and ideas, and are unorganized. Very high scores on this scale can be indicative of possible delusions or hallucinations.
Scale D: Dysthymia	Individuals scoring high here function well on a day-to-day basis but experience periods of dejection, discouragement, lack of initiative, low self-esteem, and are generally apathetic. All of the neuro-vegetative symptoms of depression are expressed during this time as well.
Scale B: Alcohol dependence	Elevated scores here may be indicative of the scales title, alcohol dependence. Additional face-to-face assessment should be conducted to ascertain the extent of the patients substance use.
Scale T: Drug dependence	Again, elevated scores here may be indicative of the scales title, drug dependence. Additional face-to-face assessment should be conducted to ascertain the extent of the patients drug dependence
Scale R: Post traumatic stress disorder (PTSD)	Individuals scoring high on this scale may have experienced an unexpected traumatic event in their lives including violence, sudden violent or unexpected death of a loved one, victim of terrorism or a terrorist attack, witness to the rampages of war or battle. They may describe reliving visual images, flashbacks, or nightmares related to the precipitating event.
Severe Clinical Syndrome Scales	
Scale	Clinical Meaning of Scales
Scale SS: Thought Disorder	Individuals scoring high on this scale often lack congruency between mood and affect, thought content and thought process, exhibit bizarre thinking, appear confused, disorganized, or withdrawn. Patients who have thought disorders are usually classified as schizophrenia, schizophreniform, or experiencing brief reactive psychosis. Additional interviewing for assessment will be necessary.
Scale CC: Major Depression	High scores on this scale are indicative of patients who are incapable of functioning in the daily routine of day-to-day activities due to their state of severe depression. They will often report suicidal ideation, a sense of hopelessness/helplessness, difficulty concentrating, and a variety of

	somatic complaints associated with depression.
Scale PP: Delusion Disorder	Elevated scores on this scale are indicative of a patient who may present acutely paranoid behavior and are highly suspicious of others. They will likely demonstrate hostility, acting as a victim of an unknown plot, vigilance, or persecutory thoughts on a grandiose scale.

Modifying Indices	
Scale	Meaning of Scales
Scale X: Disclosure	This scale is designed to measure whether the patient is being candid and self-revealing or elusive and secretive.
Scale Y: Desirability	This scale measures the extent to which the patient responses cast an image of social acceptance, moral grounding, and emotionally stable.
Scale Z: Debasement	This scale is designed to measure responses which appear unusually self-disclosing. This is often evidence of a patient who is embellishing, devaluing, or with an inclination to self deprecate.

Validity Index	
Scale	Meaning of Scales
Scale V: Validity	The validity scale is designed to maintain the reliability and integrity of this instrument. A score of 2 or more on this scale causes probable concern to question the validity of the measurement. The psychologist will make the final determination regarding the validity of the measurement.

Administration

The MCMI-III can be administered by hand or by using the MCMI-III computer scoring program if you have it available at your clinic. Computer entry is recommended due to the complexity of hand scoring the inventory. The MCMI-III consists of 175 true or false items that reflect how the individual has felt over the past few weeks. Emphasize to the patient the need to answer the inventory truthfully. The patient should also be made aware of the need to answer every item to the best of his or her ability and that skipping items may cause the inventory to become invalid. If a patient doesn't understand a word, he or she is permitted to research it in a dictionary. You should not provide your own definition as you may influence the patient's response. If patients are unsure of an item, tell them to choose a response they feel is most appropriate currently. The patients should never be helped with picking an answer. At best, they should be told to choose what is correct most of the time. Testing should last approximately 25 minutes, though the patient should be given time as needed.

Scoring

The scoring of the MCMI-III can be rather quick or quite elaborate. If testing was done on the computer, then all that is required to print the results. If the testing was done by hand, then the responses can be entered into the computer via the Manual Entry button. If a computer is not available, scoring can be done by hand with the use of the scoring templates and hand-scoring worksheets, though computer scoring is highly desirable.

428. Minnesota Multiphasic Personality Inventory II

Perhaps the most widely used self-report personality inventory, the MMPI-II is an in-depth objective inventory that can provide excellent insight about a patient for the provider with over 130 various scales (we will only be looking at the core 10 clinical scales and four validity scales). The primary purpose of the MMPI-II is to search for psychological abnormalities, though it is commonly used for job interviews; some security, nuclear or presidential support clearances, and other venues where the psychologist may feel it is suitable as an assessment tool.

You will need to be familiar with the scales outlined in this lesson. We will begin by examining the validity scales.

Validity scales

There are many validity scales; we will only be looking at the core four consisting of Cannot Say (?), Lie Score (L), Infrequency (F), and Correction (K). If the F scale is high and both the L and K scales are low, the individual may have chosen “sick” responses. This may indicate a need to be seen in a favorable light, feigning illness, or an individual with genuine emotional problems who may exaggerate the symptoms to get help. If the scores of the L and K scales are high while the score of the F scale is low, the patient may be denying symptoms, perhaps in an attempt to cover up emotional problems.

Validity Scales	
Scale	Clinical Meaning of Scales
?(Cannot Say) Scale	This scale is not plotted on the profile sheet. Its total, however, is indicated in the appropriate area on the profile sheet simply as a total. The ? scale consists of items that are omitted or double marked. Omissions exceeding 30 leave the test results highly suspect or even invalid. If the patient responds in a way that leaves just two to 10 items omitted or double marked, the test is probably valid. The higher this score, the weaker are the various other scales to indicate accuracy.
L (Lie) Scale	This scale may indicate attempts by the patient to seem perfect or desirable. Those scoring high may be rigid and lack insight. It is important to note that high scores are not a measure of one's tendency simply to lie, fabricate, or to deceive others in their day-to-day activities. Elevated L scores will adversely affect the meaning of the 10 clinical scales.
F (Infrequency) Scale	This scale represents answers given by the patient which are atypical of most respondents. The patient may be trying to look bad or to appear strange or crazy. Scoring errors may also be indicated as well as inadequate reading ability, or failure to understand the directions.
K Scale	This scale is used to mathematically adjust or to add corrective weights to five clinical scales. The tendency is for the individual to slant, in subtle ways, answers in a direction that will minimize the implication that one has poor emotional control and is personally ineffective. Examples would be that of self-enhancement, or the resistance to appear incompetent. Other examples would include those who may be poorly adjusted or one who is lacking control over one's personal life.

Clinical scales

The clinical scales on the MMPI-II are numbered and usually referred to by number rather than by name. A high or low score on a particular scale does not mean that individual has that illness. For example, an elevated 3 (Hy) score does not indicate that the individual is necessarily histrionic.

Clinical Scales	
Scale	Clinical Meaning of Scale
Scale 1 Hypochondriasis	This scale indicates excessive concern about one's health as presented through somatic complaints which have little or no organic basis.
Scale 2 Depression	This scale reflects feelings of discouragement, pessimism, and hopelessness. Also indicated are subjective depression, psychomotor retardation, physical malfunctioning, mental dullness, and brooding.
Scale 3 Hysteria	This scale indicates denial of social anxiety, the need for affection, somatic complaints, inhibition of aggression, and lassitude malaise (a malaise characterized by weakness, exhaustion or listlessness). This scale may also indicate naiveté and lack of insight.
Scale 4 Psychopathic Deviate	This scale indicates individuals who may be having difficulty with anger, familial discord, authority problems, social alienation, social imperturbability, and self-alienation.
Scale 5 Masculinity-Femininity	This scale was originally developed on men (not females) who sought psychiatric help in their homoerotic feelings toward other men and to cope with confusion over gender role. This scale is now used in correlation of its coverage of emotional reactions, interests, attitudes, and feelings about work, social relationships, and hobbies on which men and women differ.

Scale	Clinical Meaning of Scale
Scale 6 Paranoia	This scale indicates suspiciousness, feelings of persecution, and ideas of reference.
Scale 7 Psychasthenia	The term itself means a weakening of one's mental control over thoughts and actions. The scale reflects generalized anxiety and distress. Also reflected is the avowal of high moral standards, self-blame for things that go wrong and rigid efforts to control impulses.
Scale 8 Schizophrenia	This scale indicates bizarre thoughts or beliefs, confused thinking and disorganization. It also indicates a high level of stress.
Scale 9 Hypomania	This scale may indicate a high level of mental activity, egotism, and irritability. The patient that exhibits this high level of energy is often inefficient and unproductive.
Scale 0 Social Introversion	Depending on how a patient scores, this scale may be inclined to produce two distinct patient functioning. Scores above the mean reflect increasing levels of social shyness, preferences for solitary pursuits, and a lack of social assertiveness. Scores below the mean reflect the opposite tendencies toward social participation and domination.

Administration

The MMPI-II can be administered by hand with the patient filling in the circles indicating true or false or via a computer program by tapping designated keys to indicate the same. Computer entry is recommended due to the length of the inventory. The MMPI-II consists of 567 True or False items that are only relevant to the past few weeks of how a person is feeling. The patient should be instructed to answer as they truthfully feel. The patient should also be made aware that he or she needs to answer every item to the best of his or her ability and that skipping items may cause the inventory to become invalid. If he or she does not understand a word, he or she is permitted to research it in a dictionary. Providing your own definition may influence the patient's response. If the patient is unsure of an item, encourage him or her to choose a response he or she feels is most appropriate or most applicable currently. The patient should never be helped with picking an answer. At best, he or she should be encouraged to choose what is correct most of the time. The patient is permitted to take short breaks as needed, but the entire test should take place in one setting and not be separated between different days. Testing will generally last between 60 to 90 minutes, though the patient should be given time as needed.

Scoring

The scoring of the MMPI-II is another task that can vary depending on the method used for administration. If testing was done on the computer, then all that is required is that the results be printed. If the testing was done by hand, then the responses can be entered into the computer following instructions provided with the scoring program. If a computer is not available, scoring can be done by hand with the use of the scoring templates. The results will be plotted on the MMPI-II profile sheet.

429. Intellectual functioning and intelligence assessments

There are many tests available that can be used to help us assess a client's intellectual functioning. These test results can be important information because a client whose intelligence quotient (IQ) has decreased drastically may be showing signs of cognitive impairment. Some tests strictly test IQ, while others test task performance as well.

Shipley Institute of Living Scale

An older yet well-tested objective test, the Shipley Institute of Living Scale (SILS), or "Shipley" as it is commonly called, is a test designed to assess general intellectual functioning and aid in detecting cognitive impairment. The SILS is commonly used in a clinical setting to provide a quick objective estimate of a patient's general intelligence. The test was based on the idea that intellectual impairment differentially affects specific areas rather than depressing all mental abilities equally. The test was

designed to be used with adults and adolescents, ages 14 and older. It should not be used with children below age 14 because of a lack of age-appropriate norms.

Administration

The Shipley consists of two subtests: a 40-item vocabulary test, and a 20-item test of abstract thinking. The vocabulary and abstraction subtests are self-administered; they can be taken individually or in a group. The total administration time for the Shipley is 20 minutes, 10 minutes for each subtest. The two-page inventory is to be taken with a pencil (with eraser). Administer the vocabulary subtest first. If the patient accomplishes the subtest before the 10 minute time limit, do not permit the patient to turn the Shipley over to the abstraction subtest until instructed to do so by the administrator.

Ensure you have the necessary materials to conduct the test including the test form, scoring sheet, and a stopwatch for timing. The patient is asked to fill out basic demographic information such as name, sex, age, education, occupation, and date. For example, a freshman in college would list 13 years for education.

The vocabulary subtest uses a multiple-choice format. Individuals are asked to choose which of four example words “means the same or nearly the same” as the specified target word. The abstraction subtest uses a completion format. The patient is presented with a logical sequence and then asked to fill in the numbers or letters that best complete the sequence. Both the abstraction and vocabulary subtests are designed to measure overall intelligence as well as cognitive abilities. These two subtests should have a high correlation for individuals with no intellectual impairment. However, the correlation should decrease with increasing severity of impairment.

As we stated earlier, you must *always* follow the directions in the manual. The Shipley is a simple test that, as we said, can be administered individually or in a group. Read the instructions aloud to the patient as he or she follows along. Complete the example with the patient. If he or she still doesn’t understand the instructions, the first item on the subtest can be explained, but he or she will not receive credit for that item.

It’s a good idea to watch your patient complete the first few items of each subtest to ensure that the patient has an understanding of the task. The items are arranged in order of increasing difficulty; most patients are able to answer the first few items correctly. Encourage the patient to answer as many questions as possible as there is no penalty for guessing. If they seem discouraged, it is acceptable to explain that the items progressively become more difficult later on in the inventory.

Scoring

The scoring procedures provided in this lesson are complete; however, the instructions are abbreviated. For detailed information about scoring the Shipley you should refer to the Shipley manual.

The Shipley has six major scores which include:

1. Vocabulary.
2. Abstraction.
3. Combined total.
4. Conceptual Quotient (CQ).
5. Abstraction Quotient (AQ).
6. Estimated WAIS-III score.

The main scores attained from the Shipley are the CQ and the IQ. The CQ is used to estimate a person’s mental age as derived from his or her vocabulary score and abstraction scores, with 100 being average. The IQs estimated from the Shipley have a high correlation with the WAIS III, an IQ test that shall be explained later. The AQ is an additional score not used by most clinics and will not

be discussed in this lesson. Additional scoring information can be found in the Shipley manual. The Western Psychological Services Form W-177C is the scoring key for the SILS.

Weschler Adult Intelligence Scale-III

David Wechsler (1958) defines intelligence as an individual's global capacity to act purposefully, think rationally, and deal effectively with the environment. The WAIS-III is by far the most interactive of all the inventories a technician might administer. The WAIS-III is comprised of both objective and subjective test materials in a comprehensive examination of a patient's IQ. Time and multiple revisions have resulted in the WAIS-III being held in high regard as an accurate measure of one's IQ. Multiple versions of the "Weschler" exist, including one for administration to children. The WAIS-III should only be administered to patients over 16 years of age. It has three major advantages over other individual tests of intelligence. First, the WAIS-R includes measurements of both verbal and performance abilities; second, it includes both intellectual and nonintellectual factors; third, it provides three scores of intellectual functioning.

WAIS-III subtests

The WAIS-III consists of 14 subtests; seven verbal and seven performance subtests. The groupings of subtests into verbal and performance is based primarily on the type of response the patient must make and is not intended to imply two different types of intelligence. The verbal scales are used to measure an individual's verbal intelligence quotient. They consist of seven areas, also identified as subtests. The performance scales consist of five areas of evaluation which measure performance IQ.

The following chart summarizes each of the various subtests.

Verbal Scales	
Subtest	Response measurement
Vocabulary	The patient is asked to define a series of orally and visually presented words.
Similarities	The patient is asked to explain the similarity of common objects or concepts that a series of orally presented pairs of words represent.
Arithmetic	The patient is asked to solve a series of arithmetic problems mentally and respond orally.
Digit Span	The patient is asked to repeat verbatim a series of orally presented number sequences in forward and reverse order.
Information	The patient is asked to answer orally presented questions representing knowledge of common events, objects, places, and people.
Comprehension	The patient is asked to answer questions dealing with abstract social conventions, rules, and expressions
Letter-Number Sequencing	The patient is asked to simultaneously track and orally repeat a series of orally presented sequences of letters and numbers, with the letters in alphabetical order and numbers in ascending order. This can substitute for Digit Span if Digit Span is spoiled.

Performance Scales	
Subtest	Response measurement
Picture Completion	The patient is asked to identify an important missing part of common objects and settings.
Digit Symbol-Coding	The patient is asked to write corresponding symbols to numbers using a key.
Block Design	The patient is asked to replicate two-dimensional geometric patterns using a set of two-colored cubes.
Matrix Reasoning	The patient is asked to point to or say the number of the correct response from five possible choices on a series of incomplete grid patterns.
Picture Arrangement	The patient is asked to rearrange a set of pictures presented in a mixed-up order into a logical sequence.

Subtest	Response measurement
Symbol Search	The patient is presented a series of pairs, each consisting of a target symbol and a search group and is asked to indicate whether or not the target symbol is in the search group. This can substitute for Digit-Symbol Coding if that subtest is spoiled.
Object Assembly	The patient is asked to assemble pieces of a series of puzzles of common objects into a meaningful whole. This is an optional subtest that can substitute for any spoiled performance subtest.

Administration

The WAIS-III is a comprehensive step-by-step psychometric examination. Step-by-step means you as the administrator will be following instructions from the administration manual in exactly the manner presented with specific guidelines, timelines, and organization for every subtest. The manual lists all the areas to be read aloud by making the text a blue color, as well as a “Q” next to answers that would prompt the tester to gather more information. Containing 14 subtests, the testing is divided into two scales, Verbal and Performance, which are outlined above. The administration time is approximately 65 to 95 minutes, though this may be considerably shorter or longer, depending on the level of cognitive functioning of the patient.

All subtests require the manual as well as an answer sheet and should be filled in with a pencil. The administrations of all subtests follow in the order they are listed on both the manual and the answer sheet.

Some subtests might contain a reverse rule. For these the testing begins at the “Start” arrow, and if a specified number of items are answered incorrectly, the items are given in reverse. Each subtest has detailed instructions on the exact administration of the reverse rule.

Scoring

The scoring of the WAIS-III is one that also requires training and judgment. Each subtest has specific rules on scoring, though usually 1–2 points are given for each correct answer. Ideally the scoring can be accomplished while testing is being administered; yet this is not recommended without thorough training and it can prove unnecessarily distracting for the patient. Once totaling of all scores has taken place, all scores must be plotted onto a WAIS-III profile page. If a question ever arises as to what constitutes a correct response, seek advice from the provider that shall be reviewing the results.

430. Substance use and disorder assessment tools

The Substance Use Assessment Tool (SUAT) is a newly designed database to assist with the assessment, diagnosis, evaluation, reporting, and management of Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program patients.

SUAT

This lesson will provide an overview of the functionality, purpose, and your role as a Mental Health Journeyman in managing and operating the SUAT.

You have the unique opportunity as the “first generation” of 4C0s to use a standardized universal initial assessment employed Air Force wide. Undoubtedly your duties will include participation in a substance abuse evaluation and the SUAT will be a part of that assessment. You will need to educate yourself on the SUAT process. This lesson will provide an overview of the operational capabilities of the SUAT.

The purpose of the SUAT is to increase effectiveness, standardization, and efficiency in the ADAPT assessment process for patients initial entry into the ADAPT program. This program eliminates each clinic, creating or tailoring initial ADAPT intakes individually, while meeting the necessary inspection requirements of the Joint Commission and the Health Services Inspection (HSI).

The SUAT is administered to every patient entering the ADAPT clinic for evaluation and possible treatment. One objective of the SUAT is to provide a comprehensive and standardized patient intake and patient assessment for all ADAPT patients. This standardized approach includes the central storage location for the data collection provides demographic, clinical, and treatment information on all ADAPT patients. While it is promoted for its many local clinical uses, the SUAT is much more far reaching than your local application. Each assessment is forwarded via the Internet (using secure socket layer [SSL] transmission) to the Defense Information System Agency (DISA) and the information is managed by Air Force Medical Operations Agency (AFMOA). The data you collect locally will become part of a system to evaluate statistical trends, improve mandatory awareness interventions, and target secondary prevention interventions. The SUAT is accessible and useful as you may be asked to collect data or request customized queries for reports regarding ADAPT trends. Furthermore, the data is stored indefinitely. This is beneficial when you initially make contact with an ADAPT patient and query the SUAT for previous contact with ADAPT.

The SUAT is designed to automatically generate forms (SF 513, Medical Record Consultation Sheet, AF Form 422, Notification of Air Force Member's Qualification Status, SF 600, Health Record—Chronological Record of Medical Care, as well as other commonly used forms or even letters if needed), monitor outcomes, and create treatment plans based upon input provided by the patient. This computer-based data collection provides the Certified Alcohol and Drug Abuse Counselor (CADAC) or credentialed provider with a detailed assessment and highlights or “red flags” areas of the SUAT results that may be indicative of areas of concern such as self-injurious behaviors or additional mental illness. The Subjective, Objective, Assessment, Plan (SOAP) note on the computer-generated SF 600 also allows the CADAC or provider to insert additional comments, if necessary, to be included in the report. In other words, the SUAT does not replace the one-to-one interaction that must occur to establish rapport and a therapeutic relationship. The SUAT is yet another evaluative tool that is beneficial in both treatment and prevention.

Unlike traditional mental health initial intake interviews where an assessment is conducted and the patient is asked to return for additional feedback and treatment planning, the SUAT immediately provides a personalized clinical feedback report focused on harm reduction of alcohol use and misuse. Administration of the SUAT assessment program requires no more than 60 minutes per patient.

Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test (AUDIT) is an alcohol use assessment tool used to identify dangerous and harmful or excessive patterns of alcohol consumption. Developed by the World Health Organization (WHO) in 1989, it is considered a simple questionnaire revealing the potential for a patient's substance abuse. We will review key aspects of the AUDIT in this lesson.

Guidelines

The AUDIT is a 10-item screening questionnaire that can be self-administered or as an oral interview. If you read the questionnaire, it is important that the questions are read verbatim and in the sequence indicated, to allow for standardization. This simple test focuses on 3 specific areas to include 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 questions on problems caused by alcohol. Each of the responses from the 10 item questionnaire is “weighted” from 1 to 4.

Scoring

Scoring includes adding the weighted responses together to come up with a cumulative score. Scores above 8 should initiate additional inquiry from the interviewer clarifying the extent of the patient's substance use. Simply put, the higher the score the greater the likelihood the patient may have a substance dependence diagnosis.

431. Outcome Questionnaire 45.2

The Outcome Questionnaire (OQ) 45.2 is a widely used inventory that is easily self-administered and takes only a matter of five to 10 minutes. The inventory should be used as a measurement tool and is recommended at specific milestones to measure patient progress.

Objective of OQ-45.2

The OQ-45.2 is a self-report instrument consisting of 45 items. Each item is rated on a scale of 0 to 4. The patient is asked to identify the area, which would best describe how they have been feeling over the last week. This lesson will review the following areas: scoring, interpretation (from the technicians prospective), and identify the subscales and their meaning.

Scoring

The OQ-45.2 provides a total score as well as three subscores. To score the OQ-45.2, simply write the numeric value (found next to each patient response box) selected by the patient in the corresponding scoring box found to the right of each item on the right side of the questionnaire. There is one scoring box for each item which will automatically place the score for any item into its specific subscale category. You will notice that the numeric values for items 1, 12, 13, 20, 21, 24, 31, 37, and 43 are in reverse order.

When the score for each item has been written in the corresponding box, add up each vertical column of numbers, and write the total for each column in the space provided in the bottom right-hand corner of the sheet. This will leave 3 column totals, each representing one of the three subscales for the OQ.

After these three column totals are added together, a total score for the questionnaire will be obtained which should be written in the total box found at the bottom.

If a patient leaves an item blank, use the average score for the remaining subscale items rounded to the nearest whole number in place of the missing value.

Interpreting

While we can easily help in the administration of the psychological tests, it will be up to a provider to actually interpret the information. Still, it is important for technicians to know a bit about how the tests are interpreted. There are three elements to consider when interpreting the OQ-45.2:

1. The patient's answers to certain critical items.
2. The total score.
3. The subscale scores.

Critical items

While there are a lot of the questions on something like the OQ-45, there are some questions that are more pressing than the others. In the OQ-45, these items are called critical items. Any critical item with an answer other than zero should be flagged and brought to the attention of the provider. Critical items include:

- Item 8: Suicide
- Item 11, 32: Substance abuse
- Item 44: Violence

Total score

The total score will range from 0 to 180. The cut-off score of 63 or more is indicative of symptoms of clinical significance. This score is calculated by summing all 45 items. The higher the score, the more disturbed the patient.

A high score is indicative that the patient is admitting to a large number of symptoms of distress (anxiety, depression, somatic complaints, and stress) as well as difficulties in interpersonal

relationships, social role (such as work or school), and in his or her general quality of life. As was noted earlier, this inventory is often used repeatedly to measure a patient's progress between visits or at specific milestones. You should compare the total scores. If the score changes 14 points or more, it is indicated as a reliable change.

Subscales

The OQ 45.2 has separate subscales that will reflect symptoms of certain behavioral problems as well as elements of healthy behavior. The subscales include the symptom distress (SD) score, interpersonal relations (IR) score and the social role (SR) score.

SD score

The range of this scale is from 0 to 100. A score of 36 or more is indicative of symptoms of clinical significance. Research suggests that the most common disorders are anxiety disorders, affective disorders, adjustment disorders and stress related illness. The SD subscale is composed of items that have been found to reflect the symptoms of these disorders. A high score indicates the patient is bothered by these symptoms, while low scores indicate either absence or a denial of the symptoms. Symptoms scores correlate highly with various measures of depression (e.g., the BDI) and anxiety (e.g. the State-Trait Anxiety Inventory).

IR score

The range of this scale is from 0 to 44. A score of 15 or more is indicative of symptoms of clinical significance. The interpersonal relations items assess complaints such as loneliness, conflicts with others, family and marriage problems. High scores suggest difficulties in these areas, while low scores suggest both the absence of interpersonal problems as well as satisfaction with the quality of intimate relationships.

SR score

The range of this scale is from 0 to 36. A score of 12 or more is indicative of symptoms of clinical significance. The social role items measure the extent to which difficulties in the social roles of worker, homemaker or student are present. Conflicts at work, overwork, distress, and inefficiency in these roles are assessed. High scores indicate difficulty in social roles, while low scores indicate adequate social role adjustment.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

426. Beck psychological inventories

1. For what age group is the BAI suitable for administration?
2. What should you do if a patient leaves items blank or provides multiple answers for an item?
3. How long should the administration of a BDI last?
4. What is the scoring process for a BDI?

427. Millon Clinical Multiaxial Inventory-III

1. What is the MCMI-III designed to diagnose?
2. What should you do if a patient doesn't understand a word on the inventory?

428. Minnesota Multiphasic Personality Inventory II

1. What is the primary purpose of the MMPI-II?
2. What is indicated if the "F" scale is high and both the "L" and "K" scales are low?
3. What does the term *psychasthenia* mean?
4. What is the general length of time for administering the MMPI-II?

429. Intellectual functioning and intelligence assessments

1. For what purpose is the SILS commonly used in a clinical setting?
2. What are the six major scores of the SILS?
3. What are the seven verbal scale subtests of the WAIS-III?
4. What are the seven performance scale subtests of the WAIS-III?
5. What is the average administration time for the WAIS-III?

430. Substance use and disorder assessment tools

1. What is the purpose of the SUAT?
2. How is the SUAT unlike traditional mental health intake interviews?
3. What is the AUDIT designed to identify?
4. What action is required if a patient's score is above 8 on the AUDIT?

431. Outcome Questionnaire 45.2

1. What three items are considered in interpretation of the OQ-45.2?
2. What is a high total score indicative of on the OQ-45.2?
3. What is the total score range for the OQ-45.2?

Answers to Self-Test Questions**424**

1. First, it means that the test directions and questions used to evoke patient responses are always presented in the same manner. Second, it means that a norming or comparison group has been pre-tested so scores obtained by a patient are compared to the norm group.
2. The administration, scoring, and interpretation of test scores are not dependent on the subjective judgment of the test examiner.
3. To reduce the possible error factors and make the test scores more reliable.
4. First, your attention should not be so focused on the procedures that you miss behavior exhibited by the patient. Second, any inept behavior exhibited by you may cause the patient to doubt your ability to evaluate him or her objectively, which may increase the anxiety level of the patient.

425

1. Temporal format. They must search through the whole report to find behaviors that corroborate test scores.
2. Those that are invalid through an error in administration or some interruption or distraction during testing.

426

1. 17 years old and older.
2. Either clarify the items with the patient or consult a provider.
3. 5 to 10 minutes.

4. Add together the scores as they are numbered on the inventory; write in subtotals and total at the bottom of the page where it is specified.

427

1. Personality disorders and clinical syndromes.
2. Permit the patient to research the word in a dictionary. Providing your own definition may influence the patient's response.

428

1. To search for psychological abnormalities.
2. The individual may have chosen "sick" responses.
3. The weakening of one's mental control over thoughts and actions.
4. 60 to 90 minutes.

429

1. To provide a quick objective estimate of a patient's general intelligence.
2. Vocabulary, abstraction, combined total, conceptual quotient, abstraction quotient, estimated WAIS-III score.
3. Vocabulary, similarities, arithmetic, digit span, information, comprehension, letter-number sequencing.
4. Picture completion, digit symbol-coding, block design, matrix reasoning, picture arrangement, symbol search, object assembly.
5. 65 to 95 minutes.

430

1. To increase effectiveness, standardization, and efficiency in the ADAPT assessment process for patient initial entry into the ADAPT program.
2. The SUAT immediately provides a personalized clinical feedback report focused on harm reduction of alcohol use and misuse.
3. It is used to identify dangerous and harmful or excessive patterns of alcohol consumption.
4. The interviewer should clarify the extent of the patient's substance use.

431

1. Patient's answers to certain critical items, the total score, and the subscale scores.
2. Patient is admitting to a large number of symptoms of distress (anxiety, depression, somatic complaints, and stress) as well as difficulties in interpersonal relationships, social role (such as work or school), and in their general quality of life.
3. 0 to 180.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

Do not return your answer sheet to the Extension Course Program (A4L).

51. (424) When a test does what it is designed to do, this is a measure of the test's
 - a. validity.
 - b. reliability.
 - c. objectivity.
 - d. subjectivity.
52. (424) Who is the only clinical care provider specifically trained in selecting, interpreting, and providing supervision of psychological tests?
 - a. Physician.
 - b. Psychiatrist.
 - c. Psychologist.
 - d. Social worker.
53. (424) Which behavior occurs in response to a specific test question?
 - a. Elicited.
 - b. Impulsive.
 - c. Spontaneous.
 - d. Responsive.
54. (425) What is the simplest format used for reporting a psychological test session?
 - a. Temporal.
 - b. Topical.
 - c. Frontal.
 - d. Coronal.
55. (425) What format for reporting a psychological test session is the *least* convenient for the provider interpreting the test scores?
 - a. Temporal.
 - b. Topical.
 - c. Frontal.
 - d. Coronal.
56. (426) Patient responses on the BAI should reflect what period of time?
 - a. Past one day.
 - b. Past two days.
 - c. Past week.
 - d. Past two weeks.
57. (426) How long is the administration time for the BAI?
 - a. 1 to 5 minutes.
 - b. 5 to 10 minutes.
 - c. 10 to 15 minutes.
 - d. 15 to 20 minutes.

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58. (426) The BDI II is suitable for what patients over the age of
- 10.
 - 13.
 - 15.
 - 17.
59. (426) Patient responses on the BDI II should reflect what period of time?
- Past one day.
 - Past two days.
 - Past week.
 - Past two weeks.
60. (427) The MCMI III is suitable for patients over the age of
- 10.
 - 13.
 - 15.
 - 18.
61. (427) High scores on which MCMI III scale are indicative of a patient who is incapable of functioning in the daily routine of day-to-day activities.
- Thought disorder.
 - Major depression.
 - Delusion disorder.
 - Post traumatic stress disorder.
62. (427) Which MCMI III scale is designed to measure responses which appear unusually self-disclosing?
- Disclosure.
 - Desirability.
 - Debasement.
 - Verbosity.
63. (428) According to the Cannot Say (?) validity scale, how many omissions in the MMPI II will make the inventory highly suspect or even invalid?
- Over 20.
 - Over 30.
 - Over 40.
 - Over 50.
64. (429) How many minutes are allotted for each subtest on the SILS?
- 10.
 - 20.
 - 30.
 - 40.
65. (429) What does the CQ estimate on the SILS?
- Mental age.
 - Verbal age.
 - Mental intelligence.
 - Verbal intelligence.

66. (429) The WAIS III is suitable for patients over the age of
- a. 10.
 - b. 13.
 - c. 16.
 - d. 18.
67. (429) Which WAIS III subtest asks the patient to solve a series of math problems mentally and respond orally?
- a. Digit span.
 - b. Arithmetic.
 - c. Addition/Subtraction.
 - d. Digit symbol-coding.
68. (430) Each SUAT is transmitted via the Internet to the
- a. AFIA.
 - b. DISA.
 - c. AFMSA.
 - d. AFMOA.
69. (430) Who manages the SUAT information?
- a. AFIA.
 - b. DISA.
 - c. AFMSA.
 - d. AFMOA.
70. (431) All of the following are elements to consider when interpreting the OQ-45.2 *except* the
- a. total score.
 - b. subscale scores.
 - c. patient's substance use.
 - d. patient's answers to certain critical items.

**When you complete this course, please complete the student survey on the Internet at this URL:
<http://www.auecampussupport.com>. Click on Student Info and choose CDC Satisfaction
Feedback.**

Glossary of Abbreviations and Acronyms

?	Cannot Say
A&D	Admissions and Dispositions
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
ADHD	Attention Deficit/Hyperactivity Disorder
AFI	Air Force Instruction
AFMOA	Air Force Medical Operations Agency
AIDS	acquired immunodeficiency syndrome
ALD	Alcohol-induced Liver Disease
AOD	Administrative Officer of the Day
AQ	abstraction quotient
ASAM	American Society of Addiction Medicine
AUDIT	Alcohol Use Disorder Identification Test
BAI	Beck Anxiety Inventory
BDI-II	Beck Depression Inventory-Second Edition
CADAC	Certified Alcohol and Drug Abuse Counselor
CDC	career development course
CDE	commander-directed evaluation
CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol Scale-Revised
CNS	central nervous system
CONUS	continental United States
CQ	conceptual quotient
DEROS	date eligible for return from overseas
DISA	Defense Information System Agency
DOD	Department of Defense
DSM IV-TR	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision
DXM	Dextromethorphan
EPR	Enlisted Performance Report
F	Infrequency
FAP	Family Advocacy Program
FDA	Food and Drug Administration
FOIA	Freedom of Information Act
FY	fiscal year
GHB	Gamma Hydroxybutyric Acid

HIPAA	Health Insurance Portability and Accountability Act
HSI	Health Services Inspections
IAW	in accordance with
IR	interpersonal relations
IQ	intelligence quotient
K	Correction
L	lie score
LES	Leave and Earnings Statement
LOA	Letter of Admonishment
LOC	Letter of Counseling
LOR	Letter of Reprimand
LSD	Lysergic Acid Diethylamide
MCMI-III	Millon Clinical Multiaxial Inventory-Third Edition
MDMA	Methylenedioxymethamphetamine
MHS	Mental Health Systems
MHSA	Mental Health Systems Act
MI	Motivational Interviewing
MMPI-II	Minnesota Multiphasic Personality Inventory 2
MSE	mental status examination
MTF	medical treatment facility
NCOIC	noncommissioned officer in charge
NPRC	National Personnel Records Center
OIC	officer in charge
OPR	outpatient record
OPR	Officer Performance Report
OQ	Outcome Questionnaire
OSI	Office of Special Investigation
OTC	over-the-counter
PCP	Phencyclidine
PCS	permanent change of station
PRP	Personnel Reliability Program
PTSD	Post traumatic stress disorder
SD	symptom distress
SILS	Shipley Institute of Living Scale
SJA	Staff Judge Advocate
SOAP	Subjective, Objective, Assessment, Plan

SR	social role
SSL	secure socket layer
SUAT	Substance Use Assessment Tool
TDY	temporary duty
USHBP	Uniformed Services Health Benefits Program
VA	Veterans Administration
WAIS-III	Weschler Adult Intelligence Scale-Third Edition
WAPS	Weighted Airman Promotion System
WHO	World Health Organization

Student Notes

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AFSC 4C051
4C051N 03 0907
Edit Code 03