MEDICAL ISSUES

BEHAVIORAL DEFINITIONS

1. A diagnosis of a chronic illness that is not life-threatening, but necessitates changes in living.
2. A diagnosis of an acute, serious illness that is life-threatening.
3. A diagnosis of a chronic illness that eventually will lead to an early death.
4. Sad affect, social withdrawal, anxiety, loss of interest in activities, and low energy.
5. Suicidal ideation.
6. Denial of the seriousness of the medical condition.
7. Refusal to cooperate with recommended medical treatments.
8. A positive test for human immunodeficiency virus (HIV).
9. Acquired immune deficiency syndrome (AIDS).
10. Medical complications secondary to chemical dependence.
11. Psychological or behavioral factors that influence the course of the medical condition.
12. History of neglecting physical health.

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LONG-TERM GOALS

1. Medically stabilize physical condition.
2. Work through the grieving process and face with peace the reality of own death.

3. Accept emotional support from those who care, without pushing them away in anger.
4. Live life to the fullest extent possible, even though remaining time may be limited.
5. Cooperate with the medical treatment regimen without passive-aggressive or active resistance.
6. Become as knowledgeable as possible about the diagnosed condition and about living as normally as possible.
7. Reduce fear, anxiety, and worry associated with the medical condition.
8. Accept the illness, and adapt life to the necessary limitations.
9. Accept the role of psychological or behavioral factors in development of the medical condition and focus on resolution of these factors.

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SHORT-TERM OBJECTIVES

1. Describe history, symptoms, and treatment of the medical condition. (1, 2)

2. Disclose any history of or current involvement with substance abuse. (3, 4)

THERAPEUTIC INTERVENTIONS

1. In a collaborative fashion, develop a therapeutic alliance while gathering a history of the condition, including symptoms, client's reactions to the diagnosis, treatments of the condition, and prognosis.
2. With the client's informed consent, contact treating physician and family members for additional medical information regarding the client's diagnosis, treatment, and prognosis.
3. Explore and assess the role of chemical abuse on the client's medical condition.
4. Recommend that the client pursue treatment for his/her chemical

dependence (see the Substance Use chapter in this *Planner*).

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well

as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

4. Identify feelings associated with the medical condition. (9)

9. Assist the client in identifying, sorting through, and verbalizing the various feelings generated by his/her medical condition.

5. Family members share with each other feelings that are triggered by the client's medical condition. (10)

10. Meet with family members to facilitate their clarifying and sharing possible feelings of guilt, anger, helplessness, and/or sibling attention jealousy associated with the client's medical condition.

6. Identify the losses or limitations that have been experienced due to the medical condition. (11)

11. Ask the client to list the changes, losses, or limitations that have resulted from the medical condition (or assign "The Impact of My Illness" in the *Adult Psychotherapy Homework Planner* by Jongsma).

7. Verbalize an increased understanding of the steps to grieving the losses brought on by the medical condition. (12, 13)

12. Educate the client on the stages of the grieving process and answer any questions that he/she may have.

13. Suggest that the client read a book on grief and loss (e.g., *Good Grief* by Westberg; *How Can It Be Right When Everything Is All Wrong?* by Smedes; *When Bad Things Happen to Good People* by Kushner).

8. Verbalize acceptance of the reality of the medical condition and the need for treatment. (14, 15, 16, 17)

14. Gently confront the client's denial of the seriousness of his/her condition and need for compliance with medical treatment procedures; reinforce the client's acceptance of his/her medical condition and compliance with treatment.

15. Explore and process the client's fears associated with medical treatment, deterioration of physical

health, and subsequent death (or assign "How I Feel About My Medical Treatment" in the *Adult Psychotherapy Homework Planner* by Jongsma).

16. Normalize the client's feelings of grief, sadness, or anxiety associated with medical condition; encourage verbal expression of these emotions to significant others and medical personnel.

17. Assess the client for and treat his/her depression and anxiety (see the Unipolar Depression and Anxiety chapters in this *Planner*).

9. Commit to learning and implementing a proactive approach to managing personal stresses introduced by the medical condition/diagnosis. (18)

18. Use a Stress Inoculation Training approach to help the client develop knowledge and skills for managing stressful reactions to the medical condition/diagnosis; begin by using results of the assessment to identify the client's stressful reactions, identify internal and external triggers of the reactions, as well as any current coping "strengths" (see *Stress Inoculation Training* by Meichenbaum).

10. Journal thoughts, feelings, actions, and circumstances related to stressful reactions. (19)

19. Ask the client to self-monitor and collect data that identifies both internal and external triggers for his/her stressful reactions, as well as coping "strengths."

11. Verbalize an understanding of the medical condition/diagnosis and managing the stress it can create. (20, 21)

20. Collaboratively teach a conceptualization of stress that highlights the different "phases" of stress reactions including: anticipating, management/coping, handling feelings generated by the stress, and reflecting on one's coping efforts (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay); provide

	accurate information about the medical condition and stress management, correcting misinformation and debunking any myths the client may have (e.g., venting negative emotions makes them go away).
	21. Refer the client and his/her family to reading material and reliable Internet resources for accurate information regarding the medical condition and the effect stress may have on the condition (consider assigning "Pain and Stress Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).
12. Work with therapist to develop a plan for coping with stress. (22)	22. Assist the client in developing a tailored coping action plan for preventing and/or managing identified stressful reactions using skills such as relaxation, exercise, cognitive reframing, and problem-solving.
13. Learn and implement skills for managing stress. (23, 24, 25)	23. Conduct skills training, building upon effective coping strategies the client possesses, and teaching new skills tailored to the specific stressor.
	24. Train problem-focused personal and interpersonal coping skills (e.g., problem-solving, communication, conflict resolution, accessing social supports).
	25. Train emotionally focused coping skills (e.g., calming skills, perspective taking, emotional regulation, cognitive reframing).
14. Demonstrate mastery of coping skills by applying them to daily life situations. (26, 27, 28)	26. Encourage skill development by having the client rehearse and practice coping skills in session through imaginal and/or behavioral rehearsal.

27. Facilitate generalization of skills into everyday life by assigning homework (e.g., "Plan Before Acting" or "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma) in which the patient applies coping skills in graduating more demanding stressful situations; review, reinforcing success and problem-solving obstacles toward effective use of skills.

28. Help the client internalize his/her new skill set and build self-efficacy by ensuring that the client "takes credit" for improvement and makes self-attributions for change.

15. Learn and implement skills for preventing lapses back into more stressful reactions. (29)

29. Teach the client relapse prevention skills including distinguishing between a lapse and relapse, identifying and rehearsing the management of high-risk situations using skills learned in therapy, building a less stressful lifestyle, and periodically attending "booster" sessions of therapy.

16. Share with significant others efforts to adapt successfully to the medical condition/ diagnosis. (30)

30. Where appropriate, include significant others in the intervention plan to help create a reinforcing social system and social support.

17. Comply with the medication regimen and necessary medical procedures, reporting any side effects or problems to physicians or therapists. (2, 31, 32, 33)

2. With the client's informed consent, contact treating physician and family members for additional medical information regarding the client's diagnosis, treatment, and prognosis.

31. Monitor and reinforce the client's compliance with the medical treatment regimen.

	32. Explore and address the client's misconceptions, fears, and situational factors that interfere with medical treatment compliance (or assign "How I Feel About My Medical Treatment" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	33. Confront any manipulative, passive-aggressive, and denial mechanisms that block the client's compliance with the medical treatment regimen.
18. Engage in social, productive, and recreational activities that are possible in spite of medical condition. (34, 35)	34. Sort out with the client activities that he/she can still enjoy either alone or with others (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	35. Solicit a commitment from the client to increase his/her activity level by engaging in enjoyable and challenging activities; reinforce such engagement.
19. Engage in faith-based activities as a source of comfort and hope. (36)	36. Encourage the client to rely upon his/her spiritual faith promises, activities (e.g., prayer, meditation, worship, music), and fellowship as sources of support.
20. Attend a support group of others diagnosed with a similar illness. (37)	37. Refer the client to a support group of others living with a similar medical condition.
21. Partner and family members attend a support group. (38)	38. Refer family members to a community-based support group associated with the client's medical condition.
22. Implement positive imagery as a means of triggering peace of mind and reducing tension. (39, 40)	39. Teach the client the use of positive, relaxing, healing imagery to reduce stress and promote peace of mind.

40. Encourage the client to rely on faith-based promises of God's love, presence, caring, and support to bring peace of mind.

23. Identify the coping skills and sources of emotional support that have been beneficial in the past. (41, 42)

41. Probe and evaluate the client's and family members' resources of emotional support and coping skills that have been beneficial in the past (or assign "Past Successful Anxiety Coping" in the *Adult Psychotherapy Homework Planner* by Jongsma).

42. Encourage the client and his/her family members to reach out for support from church leaders, extended family, hospital social services, community support groups, and God.

24. Client's partner and family members verbalize their fears regarding the client's severely disabled life or possible death. (43)

43. Draw out from the client's partner and family members their unspoken fears about his/her possible death; empathize with their feelings of panic, helpless frustration, and anxiety; if appropriate, reassure them of God's presence as the giver and supporter of life.

25. Acknowledge any high-risk behaviors associated with sexually transmitted disease (STD). (44)

44. Assess the client's behavior for the presence of high-risk behaviors (e.g., IV drug use, unprotected sex, gay lifestyle, promiscuity) related to STD and HIV.

26. Accept the presence of an STD or HIV and follow through with medical treatment. (45, 46)

45. Refer the client to public health or a physician for STD and/or HIV testing, education, and treatment.

46. Encourage and monitor the client's follow-through on pursuing medical treatment for STD and HIV at a specialized treatment program, if necessary.

27. Identify sources of emotional distress that could have a negative impact on physical health. (47, 48)

47. Teach the client how lifestyle and emotional distress can have negative impacts on medical condition; review his/her lifestyle and emotional status to identify negative factors for physical health.

48. Assign the client to make a list of lifestyle changes he/she could make to help maintain physical health; process list.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	316	Psychological Symptoms Affecting Axis III Disorder
	309.0	Adjustment Disorder With Depressed Mood
	309.24	Adjustment Disorder With Anxiety
	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
	309.3	Adjustment Disorder With Disturbance of Conduct
	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
	309.9	Adjustment Disorder Unspecified
	296.xx	Major Depressive Disorder
	311	Depressive Disorder NOS
	300.02	Generalized Anxiety Disorder
	301.01	Panic Disorder Without Agoraphobia
	301.21	Panic Disorder With Agoraphobia
	309.81	Posttraumatic Stress Disorder

	300.00	Anxiety Disorder NOS
	V71.09	No Diagnosis or Condition on Axis I
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	_____	_____
Axis II:	799.9	Diagnosis Deferred
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
316	F54	Psychological Factors Affecting Other Medical Conditions
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.24	F43.22	Adjustment Disorder, With Anxiety
309.28	F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
309.4	F43.25	Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
311	F32.9	Unspecified Depressive Disorder
311	F32.8	Other Specified Depressive Disorder
300.02	F41.1	Generalized Anxiety Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.