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Introduction

Competent psychological assessment, including differential diagnosis, is a complex and critically important process. It sets the foundation for the professional relationship with your patient[1] and defines your approach to him or her. Therefore, to ensure competent practice, you need to start with competent assessment and diagnosis. Given your patient's set of symptoms and overall presentation, you must be able to select accurately the most appropriate diagnosis and rule out all other possibilities. This can be a daunting process, especially for budding clinicians who are only just beginning to develop their clinical skills. Thus, our goal in this book is to teach students how to think critically in a professional context and to perform assessments and diagnosis with competence. To achieve that goal, the authors of each chapter present a case that places you, the reader, in the position of the assessing or treating psychologist to provide you with the experience of making clinical decisions.

This casebook is one of several books published by the American Psychological Association (APA) to enhance psychologists' ability to diagnose using the *International Classification of Diseases, 10th Revision—Clinical Modification*

[1]In our previous text, we discussed the use of the terms *client* and *patient* by the profession and provided reasons for our use of *patient*. In this casebook, we defer to the chapter authors to use the term they typically use in their clinical settings.

http://dx.doi.org/10.1037/0000069-001
An ICD–10–CM Casebook and Workbook for Students: Psychological and Behavioral Conditions, J. B. Schaffer and E. Rodolfa (Editors)

(ICD–10–CM; World Health Organization [WHO], 2016). In our previous book, *A Student's Guide to Assessment and Diagnosis Using the ICD–10–CM: Psychological and Behavioral Conditions* (Schaffer & Rodolfa, 2016), we provided a framework to assess and diagnose mental health disorders. In this casebook, we have asked well-respected psychologists to work with one (and in some cases, more) of their students to examine and discuss how they go about making a differential diagnosis in specific diagnostic categories.

To accomplish this, we asked the authors of each chapter to use the following format to structure their chapter: Provide a brief overview of the diagnostic classification; present a case, either totally invented or greatly altered from any real case to protect confidentiality; describe the process of assessment, as well as the process of diagnosis using the ICD–10–CM; discuss the ethical issues raised by interacting with this client; summarize how to manage the issues of risk that arise with the case; and consider possible dispositions of the case, including some comments about a possible treatment plan. We are thrilled with the results! Each chapter is filled with thoughtful, helpful comments about the process of assessment and differential diagnosis.

This text comprises chapters covering 16 diagnostic categories. We chose the diagnoses on the basis of the frequency of presentation of people with these diagnoses in clinical settings, as well as the frequency in the literature and in educational settings of discussions about diagnoses, that is, the diagnoses that have the attention of the profession at this time.

We and the chapter authors hoped to make the cases as realistic as possible. Part of what this means is that they are complex, because people in the real world are complex. One consequence is that in a book of this length, every issue cannot be considered or resolved. Just like in the real world! This book is not only a casebook but also a workbook that includes a number of activities for you to consider, perhaps as part of a classroom discussion. We hope these activities, based on the case under consideration, will guide your analysis of the case and, in turn, help you consider the issues related to assessment, diagnosis, and disposition. More on this in a moment.

As you can see from the table of contents, the chapters are ordered in the way they are ordered in the ICD–10–CM; thus, each chapter in this casebook explores one diagnostic category listed in the ICD–10–CM. The only exception to this plan is Chapter 14, which covers the assessment and diagnosis of a personality disorders and provides a cutting-edge discussion of the categorical and dimensional approaches to diagnosis. We believe this discussion is critical to help students look to the future in assessment and, as a result, included this helpful discussion in this casebook.

A word about the diagnostic process that cuts across all of the chapters in this book: As we described in our previous book (Schaffer & Rodolfa, 2016), the process of assessment follows a scientific methodology of hypothesis generation, followed by data collection, resulting in hypothesis testing, leading to a conclusion about the person being assessed. The diagnostic process follows by comparing the data—in particular, in the form of signs and symptoms, and conclusions drawn with the criteria developed for specific diagnostic categories. The *Diagnostic and Statistical Manual of Mental Disorders*

(*DSM*; 5th ed., text rev.; American Psychiatric Association, 2014) system typically lists a series of symptoms representative of a particular diagnosis, with a requirement that a certain number of those symptoms be present for the diagnosis to fit. Although this seems like a precise methodology, as we pointed out in our previous book, given a range of symptoms to choose from, there can be a large number of ways to arrive at a specific diagnosis; for example, 72 combinations of symptoms might arrive at a diagnosis of major depressive disorder. Thus, the diagnostic category itself is not particularly helpful to the psychologist who is trying to understand, "Who is this person that I am working with, and why is this person the way he or she is?" The ICD–10–CM takes a different approach. It uses a kind of best-fit method. Given the data available, including signs and symptoms, but involving all of the information you have about a person, which diagnostic category best fits the particular combination of characteristics and symptoms of this individual? The authors of each of the chapters will lead you through their process of considering, then ruling out, the diagnoses that seem not to fit the data well enough, leaving you with the best remaining diagnosis or diagnoses.

We appreciate each author's hard work and believe that their effort provides you with an outstanding discussion of how to go about making a diagnosis and integrating the ICD–10–CM into the process.

How to Use This Book

As we have already described, this book is a casebook in that each chapter includes the diagnostic, ethical, risk management, and disposition issues involved in a specific case with a specific diagnosis. It is also intended as a workbook. That is, we believe that this book will be most helpful to if you don't simply read it from beginning to end—although we do hope you make it to the end!—but by reading each chapter in conjunction with other resources, such as a diagnostic manual or textbook, and by stopping periodically to think about what you perceive to be the most important issues being raised by the case and the resultant discussion. In particular, as we wrote this book, we had in mind using it in a graduate course in assessment, psychopathology, or treatment. We believe that the more time you spend thinking about how a psychologist goes about assessing and diagnosing a patient, the more useful this book will be for you and the more prepared you will be down the road to function as a competent psychologist.

This book also covers a great deal of ground—namely, 16 diagnostic categories and complex decision-making processes involving data collection and diagnosis. In so short a text, we cannot cover everything that is part of that process. Therefore, this volume is meant to be used in conjunction with other texts on the ICD–10–CM (e.g., Schaffer & Rodolfa, 2016; Goodheart, 2014), as well as texts on psychopathology and psychological treatment (see Chapter 10 in Schaffer & Rodolfa, 2016, for additional resources).

To assist you in this process, the chapter authors provide Activity Boxes to stimulate your thinking about the specific case and the issues it raises for a psychologist. These Activity Boxes will appear five times throughout the chapter. The first activity will appear after you have read the case and typically will ask you to consider issues related to the assessment. The second activity will ask you to apply information learned from the assessment to possible diagnoses. The third activity will raise ethical issues specifically about the case under discussion, the fourth activity will help you examine risk management issues, and the final will raise issues about the disposition of the case.

Many of the issues to consider actually crosscut all of the cases and diagnostic categories. Therefore, rather than repeat the same or very similar activities throughout the chapters, in the activity that follows (Activity 0.1), we provide you with a list of questions you can consult as you read through each chapter. You might dog-ear this page so you can turn back to it easily and often as you read through the following chapters. In addition to these questions, the chapter authors have provided case-specific questions for you to ponder and discuss in class and with colleagues. We hope you will take advantage of all of these questions to stimulate your thinking; we believe that these exercises will help you think like a psychologist.

Once you have read through one of the case descriptions, a number of questions will likely come to your mind. Here is a list of some that we recommend you spend some time thinking about before you continue with the chapter.

ACTIVITY 0.1: General Questions About the Case

- What are your initial impressions of this person?
- What are this person's primary concerns?
- How able is this person to function?
- Do you have any particular worries about this person?
- Based on your theoretical orientation, what are the fundamental psychological issues this person is experiencing?
- Why has this person come in to see you?
- What additional information do you want to know?
- What questions would you plan to ask in your first contact with this person?
- Write some thoughts about how you might phrase your questions to the patient and, perhaps, to other professionals or family members whom you might interview or consult with.

Once you have given these questions some thought, but before you read beyond the case description, we encourage you to turn your focus to diagnostic considerations. Here are some questions you might spend some time considering and researching. We encourage you to find helpful sources to assist you in making an appropriate differential diagnosis. The chapter authors have provided you a number of references they use to help them as they rule out and rule in diagnoses.

ACTIVITY 0.2: General Diagnostic Considerations

- Make a list of ICD–10–CM diagnoses that you would want to consider, listing them from most to least likely.
- What are the behaviors, emotions, and/or cognitions that lead you to these diagnostic hypotheses?
- In addition to the general information you would like, what specific data will you need to rule out diagnoses you have listed?
- Would psychological test data be helpful?

This would be a good time to check a diagnostic manual or textbook that describes the particular disorders you are considering. It might also be helpful to create a spreadsheet, listing possible symptoms based on a diagnostic manual and the specific manifestations of those symptoms, if present, in this person.

Before you start the Ethics section of each chapter, here are some issues to consider and think about.

ACTIVITY 0.3: General Ethics Questions

- Refer to the APA (2017) and/or Canadian Psychological Association (CPA; 2017) codes of ethics. List any ethical concerns or dilemmas you can identify regarding the case.
- Are there any safety, privacy, or competency concerns that you should be aware of?
- As you consider where your actions might take you, can you conceive of any "slippery slopes" in dealing with this type of patient? That is, are there behaviors on your part that might seem ethical initially or on the surface but could lead to ethical problems down the road?

Having considered ways to protect the client in the Ethics section, now consider ways of protecting yourself by thinking about these questions.

ACTIVITY 0.4: Risk Management Questions

- What risks could you imagine facing when working with this person?
- What actions do you need to consider from your first professional contact with this person?
- How can you protect yourself without violating the ethical rights of the patient?

Now you have reached the ultimate goal of the psychological assessment process, deciding how you are going to proceed, whether by offering treatment yourself, making

a referral to someone else, or offering a recommendation to the referring person. Here are some questions you will need to consider with every person you work with, regardless of what your eventual disposition is.

ACTIVITY 0.5: Disposition Issues

- What presenting problems need to be addressed?
- How would you prioritize the presenting problems to determine what to do first?
- What goals has the patient identified?
- What goals do you have for this patient?
- What interventions do you think would be most appropriate, and why did you choose them?
- What results or trends would you expect to see over time?
- How would you evaluate whether your treatment of this person is successful?

The ICD–10–CM: The Foundation for Diagnosis

The ICD–10–CM is a compendium of diagnoses that cover causes of mortality (death) and morbidity (symptoms and illness), not a diagnostic manual that provides criteria for making a diagnosis. The ICD–10–CM assumes that the professional using this system has sufficient expertise and knowledge to apply the best-fit diagnosis to a constellation of symptoms in a reasonably reliable and valid fashion. In other words, the fact that the ICD–10–CM is not a manual provides the practitioner with considerable flexibility, as opposed to a manualized system like the *DSM*. Consult other texts on how to use the ICD–10–CM in your practice, such as Chapter 1 in our previous book (Schaffer & Rodolfa, 2016) or Carol Goodheart's (2014) primer for ICD–10–CM users.

As you enter this profession, it may seem that some diagnoses are not as challenging to make; however, as you read this casebook, you will note that the cluster of symptoms that make up a diagnosis is often not quite so clear-cut. The chapter authors discuss how they make sense of these diagnoses as they discuss their assessments and understanding of their clients' symptom presentation.

The authors use a variety of resources as a foundation to discuss the disorders they present to you. For instance, some have chosen to use the *ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*, typically referred to as the *Blue Book* (WHO, 1993). They believe the convenience and availability of the *Blue Book* outweigh the disadvantages and that the diagnostic criteria are adequately current for their diagnostic category. We discussed the issues involved in using this particular resource in more detail in our other book in this series (Schaffer & Rodolfa, 2016). Although the *Blue Book* has been in existence for some time, it is easily and inexpensively accessible through the World Health Organization (WHO, 1993). Other authors have chosen to rely on various texts as diagnostic manuals for the diagnosis they make in their chapter because they are more current or complete than the *Blue Book*. In that case they have provided you with references to that text.

In your practice, you should consider these perspectives along with the texts you use in your graduate program's psychopathology course. And, of course, after graduation you should stay current with the literature and decide which diagnostic texts are most appropriate for the individuals with whom you work.

The ICD–10–CM is available in PDF format free of charge from the U.S. government's Centers for Medicare and Medicaid Services (2017) website (https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html). The *Blue Book* (WHO, 1993) is available free of charge on the WHO website (http://www.who.int/classifications/icd/en/bluebook.pdf).

Issues That Cut Across Chapters

A number of issues are discussed in more than one chapter. In particular, three issues—competence, suicide assessment, and self-care—are raised by many authors. As a result, we believe that it will be helpful and will prevent simple repetition to discuss briefly these three issues in this introduction, so we have asked the authors who raise them to limit their discussions in their chapters.

As you may be able to intuit from your experiences and classes in psychology, the issues of the therapist's competence, the assessment of the patient's suicidality, and the concern of therapist self-care are encountered regularly during one's training and career. This brief overview will help provide a foundation for your understanding when the chapter authors discuss these issues in the context of the cases they present.

COMPETENT PRACTICE IN PSYCHOLOGY

Competent practice is based on a combination of knowledge, skills and values/attitudes (APA Commission on Accreditation, 2015; Association of State and Provincial Psychology Boards, 2014; Rodolfa et al., 2013). To be competent, a psychologist must have a basic foundation of knowledge; effectively display the skills needed to assess, diagnose, and treat; be open to new perspectives through continued learning and consultation with others as needed; and have a sound understanding of and ability to apply the ethical standards of the profession. Both the APA (2017) *Ethical Principles of Psychologists and Code of Conduct* and the CPA (2017) *Canadian Code of Ethics for Psychologists* emphasize the importance of competency (APA Ethics Code, Standard 2.01, Boundaries of Competence; CPA Code of Ethics, Standard II.6) in the practice of psychology.

The issue of competent practice is raised by each of the authors in this casebook. These authors challenge you to consider what steps you will need to take to develop or enhance your competency in the assessment and treatment of the described disorders. We believe competency is one of the most critical concepts in the practice of psychology. As a student, you are currently going through the process of gaining competency in the profession of psychology. Your classes and your practicum, internship, and postdoctoral fellowship will all greatly enhance your competency. Each of these experiences is created to help you in a sequential, graded, and cumulative way

(APA Commission on Accreditation, 2015) to develop the foundational and functional knowledge, skills, and values (Rodolfa et al., 2005) to practice as a competent psychologist. Yet even after you complete your degree and receive your license to practice psychology independently, it is incumbent on you to continue the process of lifelong learning (see Wise et al., 2010). Your education does not end with your degree. It does not even end at licensure because maintaining competence is a career-long and lifelong process. It is with this mind-set that we encourage you to read this casebook.

SUICIDE ASSESSMENT

Numerous useful articles and books have been written about assessing suicidal ideation and behavior (Kleespies, 2014). There is a reason for that. Suicide assessment is a critically important aspect of the work of a psychologist: 13.4 per 100,000 people in the United States die by suicide each year (Centers for Disease Control and Prevention, National Center for Health Statistics, 2017). This translates to almost 45,000 people each year. That makes the probability of your having to confront the possibility of suicide in your practice at some point in your career very high. In addition, working with a suicidal client is a difficult and stressful endeavor. Kleespies and Dettmer (2000) reported that conducting a suicide assessment is challenging, at times aversive, and perhaps the most stressful activity performed by a psychologist. In Pope and Vasquez's (2016) exploration of psychology ethics, Linehan indicated that one of the difficulties in responding to suicidal clients is that practitioners do not have appropriate training and experience to assess and treat them. Sommers-Flanagan and Shaw (2017) noted that psychologists' graduate curriculum is not consistently infused with training to enhance suicidal competencies. We hope that reading about and discussing the issues of suicidal behavior presented in this casebook will be a first (or second) step to help you become better prepared to respond when a client presents with suicidal ideation or behavior.

The following comments are provided to give you an overview of the assessment and intervention with a client expressing suicidal ideation. Pope and Vasquez (2016) described 22 risk factors that may be useful for a clinician to take into consideration, although there are limitations to these factors discussed by Pope and Vasquez (i.e., factors may interact, factors can change, factors are not comprehensive or conclusive). These factors include a verbal warning, having a plan, prior attempts, communicating intent indirectly, and depressive disorders, among many others. Rogers and Joiner (2017) noted that these risk factors focus primarily on suicidal ideation rather than suicide attempts. In an interesting study, they highlighted the importance that rumination and brooding, rather than problem-solving, play in placing individuals on the path toward suicide attempts instead of considering alternatives to suicide.

Franklin et al. (2017), in a meta-analysis of 50 years of research of suicidal thoughts and behaviors (STB), found that the consideration of STB risk factors as well as protective factors has limited utility because of methodological constraints in the studies they analyzed. They emphasized that STB risk factors are based on rational derivations from expert consensus. However, although they have not been evaluated

by the literature, they may be helpful. As all authors agree, the roles of STB risk factors are complex and likely interactive, and using only single risk factors yields limited utility in predicting STBs. Current research is zeroing in on the most important factors in influencing suicidal tendencies (see Witte, Holm-Denoma, Zuromski, Gauthier, & Ruscio, 2017). Such research makes keeping up with the current literature in this area especially crucial.

Sommers-Flanagan and Shaw (2017) underscored the importance of keeping up-to-date with the suicide assessment and intervention literature, documenting the following six shifts in current research:

> (a) acknowledgment that suicide risk factors are not especially helpful to psychologist-practitioners; (b) a movement away from medical model formulations and toward social constructionist and collaborative orientations [i.e., movement away from viewing suicidal behavior as a specific illness and toward a collaborative understanding of the client's suicidal experience]; (c) progress in theoretical knowledge pertaining to suicidal individuals; (d) recognition that the clinical encounter and comprehensive suicide assessment interviews are essential to developing and maintaining a therapeutic relationship; (e) advancements in how clinicians question patients about suicide ideation; and (f) methods for monitoring suicide ideation over time. (p. 98)

Sommers-Flanagan and Shaw emphasized that "psychologists who understand and apply these approaches to suicide risk assessment will be more capable of conducting competent suicide assessment and treatment and thereby contribute to national suicide prevention efforts" (p. 98).

Although critical to practice, competence in suicide assessment will not be achieved by reading this book—or any book, for that matter. We hope that this text and the related resources referenced herein will help you develop the foundational knowledge to enter supervised practice experiences (i.e., practicum and internship) to take additional steps to achieve competence.

SELF-CARE

Acquiring the knowledge and skills necessary for the competent practice of psychology allows one to develop a sense of self-efficacy, the experience and belief that one is able to manage life's challenges effectively (Bandura, 1977, 1997). Part of what self-efficacy means is that a person is able to respond to life's challenges without feeling overwhelmed by them, a process referred to as *resilience* (see Rutter, 2012). Research has demonstrated that support systems, both within the family (Laub & Sampson, 2003) and beyond the family (Masten & Tellegen, 2012), provide important protective factors for the development and maintenance of resilience and in turn competence.

Competence is also developed through gaining experience (skill) in a wide range of experiences. This wide range of skill development may increase a person's adaptability and ability to manage new and challenging situations (Chandra & Leong, 2016). Thus, one of our messages to you, our reader, is this: Develop supportive social networks, both professionally and personally, and accumulate many different kinds

of experiences, both as a psychologist and otherwise, and, in the process, seek out consultation and supervision from others who can assist you in managing the new challenges in ways that lead to "steeling" (Rutter, 2012) rather than capitulation.

But this is not the end of the story. We do want to emphasize that the process (the lifelong process) of achieving competence is not easy. The courses you take and the supervised training you are receiving to acquire competence as a psychologist constitute an arduous journey. And once you become a psychologist, the work will continue to be taxing. Guy, Poelstra, and Stark (1989) reported that 75% of psychologists surveyed realized that they experienced significant work-related distress, and 37% acknowledged that their distress was negatively affecting their work. These are striking numbers and ones that you should heed, particularly in light of Richards, Campenni, and Muse-Burke's (2010) study, which suggests that mental health professionals are particularly susceptible to burnout and emotional and functional impairment within their professional roles.

The APA (2017) Ethics Code and the CPA (2017) Code of Ethics that are referred to throughout this casebook provide the foundation for the necessity of self-care. On the basis of the guidance provided by these codes, it is essential that psychologists and psychology trainees take steps to prepare themselves—that is, take care of themselves—for the hard work that lies ahead.

Richards et al. (2010) reported that there is no one definition of self-care, but they described the following possibilities: psychological, physical, and spiritual efforts and support with the goal of enhancing subjective well-being. Richards and coworkers discussed a significant positive relationship among self-care, self-awareness, and well-being.

In a thoughtful discussion of the work of a mental health practitioner, Svokholt (2012) acknowledged the intensity of the therapeutic process as an interpersonal situation with high stakes, high vulnerability, and great potential for personal harm to the client when practiced inadequately. Svokholt asserted that to be successful, the mental health practitioner must be personally and emotionally available throughout his or her clinical work with clients. He suggested that mental health practitioners ensure high levels of personal and emotional functioning by engaging in positive and enjoyable activities (i.e., self-care activities) that stimulate emotional coping and build up emotional reserves so they are more resilient and are able to practice in a consistently competent manner.

Self-care also involves using your best judgment, based on the best evidence available (and, in our field, as in others, the best evidence is gained through using a scientific methodology; see Schaffer & Rodolfa, 2016), thus training yourself to ask questions and make decisions based on the evidence before you. This casebook offers many examples of psychologists using the scientific method to determine a diagnosis and then taking the next step in the process of assessment and treatment.

Although it is a broad topic, when discussing self-care, as when discussing so many important topics in psychology, specificity is important. Myers et al. (2012) found that when self-care is being promoted to graduate students, it is important to emphasize specific behaviors that will be useful in managing stress rather than simply encouraging an ambiguous concept of self-care. Thus, when thinking about

self-care, think in specifics: How much sleep am I getting? Am I exercising? When was the last time I had a social contact? What am I doing to manage my emotional responses to the clients I am assessing and treating? How can I help myself live in this moment? Taking specific steps to care for yourself will help you manage your stress and in turn help you acquire the knowledge and skills to competently assess and diagnose your clients.

As we stated at the beginning of this Introduction, competent assessment and diagnosis set the foundation for competent psychological practice. They are critically important processes, yet they are also complex and difficult to master. Our hope is that this casebook, in combination with our previous text, will help you increase your competence in assessing and diagnosing patients using the ICD–10–CM, thus preparing you to practice competently throughout your career as a psychologist.

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