NCMHCE Quick Reference

92 Diagnoses · ICD-10 Codes · First-Line Treatments

PassReady Prep · GA Integrated Therapeutic Perspectives LLC

Depressive

Major Depressive Disorder, Moderate (F33.1)
First-line: CBT or IPT + consider SSRI

Major Depressive Disorder, Severe (F33.2)
First-line: SSRI/SNRI + psychotherapy; assess suicide risk

Persistent Depressive Disorder (F34.1)
First-line: CBT + SSRI (combination superior)

Premenstrual Dysphoric Disorder (F32.81)
First-line: SSRI (continuous or luteal-phase); CBT

Disruptive Mood Dysregulation Disorder (F34.81)
First-line: Parent training + CBT; stimulant if comorbid ADHD

Major Depressive Disorder, with Peripartum Onset (F53.0)
First-line: IPT or CBT preferred; SSRI if moderate-severe

Anxiety

Generalized Anxiety Disorder (F41.1)
First-line: CBT with relaxation training; SSRI/SNRI

Panic Disorder (F41.0)
First-line: CBT with interoceptive exposure

Social Anxiety Disorder (F40.10)
First-line: CBT with in vivo exposure; SSRI

Specific Phobia (F40.218)
First-line: In vivo graduated exposure therapy

Agoraphobia (F40.00)
First-line: CBT with graduated situational exposure

Separation Anxiety Disorder (F93.0)
First-line: CBT with graduated exposure + parent training

Selective Mutism (F94.0)
First-line: Behavioral intervention with graduated exposure

Trauma

Posttraumatic Stress Disorder (F43.10)
First-line: CPT, PE, or EMDR (trauma-focused CBT)

Acute Stress Disorder (F43.0)
First-line: Brief trauma-focused CBT

Adjustment Disorder, with Mixed Anxiety and Depressed Mood (F43.23)
First-line: Supportive counseling + CBT; time-limited

Adjustment Disorder, with Depressed Mood (F43.21)
First-line: Brief supportive therapy; CBT; address stressor

Reactive Attachment Disorder (F94.1)
First-line: Attachment-focused therapy with stable caregiver

Prolonged Grief Disorder (F43.81)
First-line: Complicated grief treatment (CGT); targeted CBT

Substance

Alcohol Use Disorder, Moderate (F10.20)
First-line: MI + CBT/12-step; naltrexone or acamprosate

Alcohol Use Disorder, Severe (F10.20)
First-line: Medically supervised detox + MAT + counseling

Alcohol Withdrawal (F10.230)
First-line: Medical management (benzodiazepines); CIWA monitoring

Opioid Use Disorder, Severe (F11.20)
First-line: MAT (buprenorphine/methadone) + behavioral counseling

Opioid Withdrawal (F11.23)
First-line: MAT initiation; symptom management

Stimulant Use Disorder (Cocaine) (F14.20)
First-line: CBT + CM (contingency management); no approved medication

Stimulant Intoxication (F14.129)
First-line: Consult clinical practice guidelines

Cannabis Use Disorder, Moderate (F12.20)
First-line: MI + CBT; no FDA-approved medication

Sedative Use Disorder (F13.20)
First-line: Medically supervised taper; CBT

Tobacco Use Disorder, Moderate (F17.200)
First-line: Nicotine replacement + behavioral counseling

Gambling Disorder (F63.0)
First-line: CBT + GA support; address cognitive distortions

Personality

Borderline Personality Disorder (F60.3)
First-line: DBT (Dialectical Behavior Therapy)

Narcissistic Personality Disorder (F60.81)

First-line: Schema therapy or transference-focused therapy

Antisocial Personality Disorder (F60.2)
First-line: CBT for criminogenic thinking; limited evidence

Avoidant Personality Disorder (F60.6)
First-line: CBT with graduated exposure + schema therapy

Dependent Personality Disorder (F60.7)
First-line: CBT building autonomy + assertiveness training

Obsessive-Compulsive Personality Disorder (F60.5)
First-line: CBT targeting rigidity; psychodynamic

Schizotypal Personality Disorder (F21)
First-line: CBT for social skills; low-dose antipsychotic if severe

Paranoid Personality Disorder (F60.0)
First-line: CBT building trust; avoid confrontation

Schizoid Personality Disorder (F60.1)
First-line: Supportive therapy; gradual social engagement

Histrionic Personality Disorder (F60.4)
First-line: Psychodynamic or CBT; address attention-seeking patterns

Bipolar

Bipolar I Disorder, Current Episode Manic (F31.13)
First-line: Mood stabilizer + atypical antipsychotic

Bipolar I Disorder, Current Episode Depressed (F31.31)
First-line: Quetiapine or lurasidone; careful with antidepressants

Bipolar II Disorder (F31.81)
First-line: Mood stabilizer + IPSRT or CBT; lamotrigine

Cyclothymic Disorder (F34.0)
First-line: Mood stabilizer (lower dose); psychoeducation + CBT

Neurodevelopmental

Attention-Deficit/Hyperactivity Disorder, Combined (F90.2)
First-line: Stimulant + behavioral strategies + accommodations

Attention-Deficit/Hyperactivity Disorder, Inattentive (F90.0)
First-line: Stimulant or atomoxetine + organizational skills

Autism Spectrum Disorder (F84.0)
First-line: ABA + social skills training + family support

Specific Learning Disorder (F81.0)
First-line: Specialized educational intervention; IEP/504

Intellectual Developmental Disorder, Mild (F70)
First-line: Adaptive skills training; supported living/employment

Tourette's Disorder (F95.2)
First-line: CBIT (behavioral); medication if severe (antipsychotics)

Neurocognitive

Delirium (F05)
First-line: Medical emergency — treat underlying cause

Major Neurocognitive Disorder due to Alzheimer's Disease (F02.80)
First-line: Cholinesterase inhibitors; caregiver support; safety planning

Major Neurocognitive Disorder due to Vascular Disease (F01.50)
First-line: Manage cardiovascular risk factors; cognitive rehab

Mild Neurocognitive Disorder (G31.84)
First-line: Cognitive rehab; lifestyle modifications; monitoring

OCD-Related

Obsessive-Compulsive Disorder (F42.2)
First-line: ERP + SSRI

Body Dysmorphic Disorder (F45.22)
First-line: CBT-BDD + SSRI

Hoarding Disorder (F42.3)
First-line: Specialized CBT for hoarding

Trichotillomania (F63.3)
First-line: Habit Reversal Training + stimulus control

Excoriation Disorder (L98.1)
First-line: Habit Reversal Training; SSRI

Psychotic

Schizophrenia (F20.9)
First-line: Antipsychotic + CBTp + psychosocial rehab

Schizoaffective Disorder, Bipolar Type (F25.0)
First-line: Antipsychotic + mood stabilizer + CBTp

Schizophreniform Disorder (F20.81)
First-line: Antipsychotic; monitor for progression to schizophrenia

Brief Psychotic Disorder (F23)
First-line: Short-term antipsychotic; resolves <1 month

Delusional Disorder (F22)
First-line: Antipsychotic (limited response); CBT for alliance

Eating

Anorexia Nervosa, Restricting Type (F50.01)
First-line: FBT (adolescents) or CBT-E; medical monitoring

Bulimia Nervosa (F50.2)
First-line: CBT-E; SSRI (fluoxetine)

Binge-Eating Disorder (F50.81)
First-line: CBT-E or IPT; lisdexamfetamine

Avoidant/Restrictive Food Intake Disorder (F50.82)
First-line: Gradual food exposure; family-based; nutritional support

Crisis

Suicidal Behavior / Acute Risk (R45.851)
First-line: C-SSRS + safety plan + means restriction + level of care

Nonsuicidal Self-Injury (R45.88)
First-line: DBT skills + functional assessment

Acute Crisis / Decompensation (F43.0)
First-line: Stabilize + assess safety + level of care determination

Homicidal Ideation / Threat Assessment (R45.850)
First-line: Duty to warn/protect + safety assessment + documentation

Disruptive

Oppositional Defiant Disorder (F91.3)
First-line: Parent Management Training + child CBT

Conduct Disorder, Adolescent-Onset Type (F91.2)
First-line: MST or Functional Family Therapy

Intermittent Explosive Disorder (F63.81)
First-line: CBT anger management; SSRI

Somatic

Somatic Symptom Disorder (F45.1)
First-line: CBT for health anxiety; scheduled visits

Illness Anxiety Disorder (F45.21)
First-line: CBT targeting health preoccupation

Functional Neurological Symptom Disorder (F44.4)
First-line: CBT + physical therapy; validate symptoms

Factitious Disorder (F68.10)
First-line: Gentle confrontation; address underlying needs

Dissociative

Dissociative Identity Disorder (F44.81)
First-line: Phase-oriented: stabilize, process, integrate

Dissociative Amnesia (F44.0)
First-line: Psychotherapy for underlying trauma

Depersonalization/Derealization Disorder (F48.1)
First-line: CBT + grounding; treat comorbid anxiety/depression

Sleep

Insomnia Disorder, Chronic (F51.01)
First-line: CBT-I (sleep restriction + stimulus control)

Nightmare Disorder (F51.5)
First-line: Image Rehearsal Therapy; prazosin if trauma-related

Hypersomnolence Disorder (F51.11)
First-line: Behavioral strategies; modafinil; treat underlying cause

Sexual-Gender

Gender Dysphoria in Adolescents/Adults (F64.0)
First-line: Affirmative therapy + medical referral

Female Sexual Interest/Arousal Disorder (F52.22)
First-line: CBT + sensate focus; address relationship factors

Erectile Disorder (F52.21)
First-line: CBT + behavioral techniques; medical eval

Ethics

Confidentiality / Duty-to-Warn Dilemma (Z65.3)
First-line: Ethical decision-making model; consult; document

Boundary / Dual-Relationship Dilemma (Z65.8)
First-line: Evaluate risk; consult; document; refer if needed

Mandated Reporting Decision (Z65.8)
First-line: Report per state law; document; inform client if safe

Informed Consent / Competence Dilemma (Z65.8)
First-line: Review capacity; document decision process

Risk, Safety & Triage

NCMHCE quick reference · CounselorReady™ — safety is assessed FIRST, before every other clinical decision.

Suicide risk — what stacks the acuity

Screen in order: **ideation** → **plan** → **access to means** → **intent** → **protective factors.** A specific plan **with access to means** (or clear intent) is the highest-weight combination. Prior attempt is among the strongest predictors even when current ideation is denied.

Assessment	Response
Structured screen	Administer **C-SSRS / Columbia** — assess before acting.
Moderate risk, can stay safe	Collaborative **safety plan (Stanley-Brown)** + **means restriction** + increase contact.
High risk (plan + means/intent)	Least-restrictive setting that keeps client safe; consider hospitalization; do not leave alone.
Never	**No-suicide / no-harm contracts** — not evidence-based. Use a safety plan.

Duty to warn / protect (harm to others)

Triggered only by a **specific, imminent** threat to an **identifiable victim**. Then warn/notify per state statute and **document** — disclose the **minimum necessary**. Vague anger → document & monitor.

Level of care — least restrictive that keeps the client safe

Setting	When
Inpatient / crisis	Acute danger or medical instability; 24/7 supervision.
PHP	Safe overnight but needs ~6+ hrs/day structure.
IOP	Needs >weekly structure; still functions at home/work (3–5 days/wk).
Outpatient	Mild–moderate, adequate functioning — the default.

Withdrawal danger ranking (which can kill)

Substance	Danger → action
Alcohol / benzodiazepines	Can be **fatal** (seizures, DTs). Assess **CIWA-Ar**; medically supervised detox. Never advise abrupt cessation.
Opioids	Miserable, rarely fatal. **MAT** referral; discomfort drives relapse/overdose risk.
Stimulants / cannabis	Primarily psychological; outpatient supportive management.

Ethics & Legal Duties

NCMHCE quick reference · CounselorReady™ — the limits of confidentiality, and the pathways that pierce it.

Three triggers that pierce confidentiality (don’t blur them)

Trigger	Pathway
Threat to identifiable person	**Duty to warn/protect** — specific + imminent + identifiable victim → warn/notify per statute; document.
Suspected abuse (child / elder / dependent adult)	**Mandated report** on **reasonable suspicion — not proof.** You report; you do **not** investigate.
Valid court order	Release **minimum necessary.** A **subpoena** ≠ **court order** — verify validity, consult before releasing.

Informed consent & capacity

Capacity = **understand, appreciate, reason, express a choice.** Unclear capacity + no proxy → **formal capacity evaluation** before consent-dependent treatment. Minors: parent/guardian **consent** + minor **assent**; know state exceptions (some allow independent consent for substance/mental-health/reproductive care).

Boundaries & dual relationships (ACA A.5)

Situation	Rule
Sexual/romantic with current client	**Prohibited — no exceptions.**
Sexual with former client	Prohibited for **5 years**; even after, burden is on counselor to show no exploitation.
Unavoidable (rural/small community)	**Manage**, don’t reflexively avoid: document, informed consent, boundaries, consultation.

When in doubt

Apply a structured model (**Forester-Miller & Davis**): identify competing principles → **consult** → act within law/policy → **document** contemporaneously. The exam rewards minimum-necessary disclosure + documentation, not “report everything” or “protect confidentiality at all costs.”

Treatment Decision Rules

NCMHCE quick reference · CounselorReady™ — what to do next, for whom, and in what order.

Cross-cutting rules (apply everywhere)

1. Stage of change gates treatment. Precontemplation → **MI only** (never skills/groups/abstinence-as-condition). **2. Stabilize first:** safety, mania, acute withdrawal, medical instability before protocol/trauma/insight work. **3. Sequence beats simultaneity.** **4. Scope:** counselors **refer** for medication and never name specific agents.

Sequencing traps (correct order)

Scenario	Correct first action	The trap
BPD + self-harm	**Behavioral chain analysis**, then replacement skill	Teaching a skill before the chain analysis
Bipolar depression	Refer for **mood stabilization**, then add therapy	Intensive therapy / antidepressant monotherapy while cycling
Anorexia, unstable vitals	**Medical stabilization** first	Starting CBT-E / FBT while medically unstable
PTSD + SUD (not acute w/d)	**Integrated/concurrent** (COPE)	“Get sober first,” delaying trauma work
SUD, precontemplation	**Motivational interviewing**	Confronting denial; requiring abstinence to treat

Contraindications — when to AVOID

Treatment	Avoid when…
Exposure therapy	Active psychosis, severe dissociation, or acute SI without a safety plan
CBT-I sleep restriction	**Bipolar I** (mania risk); seizure disorders
Antidepressant monotherapy	Any history of hypomania/mania (screen first — switch risk)
Family-Based Treatment (anorexia)	Active parental abuse; parents can’t supervise meals

Assessment Tools by Domain

NCMHCE quick reference · CounselorReady™ — the right instrument, and self-report vs clinician-administered.

Match the tool to the question

Domain	Instrument (S = self-report, C = clinician)	Note
Suicide risk	**C-SSRS / Columbia** (C)	Assess before any safety plan
Safety planning	**Stanley-Brown SPI**	After risk is assessed; not a contract
Depression	**PHQ-9** (S) · HAM-D (C)	PHQ-9 for monitoring; HAM-D is clinician-rated
Anxiety	**GAD-7** (S) · PDSS (C, panic)	Match to the disorder
Bipolar screen	**MDQ** (S)	Screen before treating depression
Trauma / PTSD	**PCL-5** (S) · **CAPS-5** (C)	CAPS-5 = gold-standard diagnosis
Substance — screen	**AUDIT / CAGE / DAST** (S)	Screening, not withdrawal
Substance — withdrawal	**CIWA-Ar** (C)	Tracks alcohol-withdrawal severity
Cognition	**MoCA** > MMSE	MoCA more sensitive to mild impairment; rule out delirium first
Eating	**SCOFF** (S) + vitals/labs	Medical stability before psychosocial
Child / ADHD	**Vanderbilt**, multi-informant	Cross-setting; developmental history
Foundational	**Clinical interview + MSE**	Ground assessment before instruments
Cultural context	**Cultural Formulation Interview**	Avoid over-/under-pathologizing

Defense Mechanisms & Cognitive Distortions

NCMHCE quick reference · CounselorReady™ — name the mechanism, spot the distortion.

Defense mechanisms (mature → immature)

Mechanism	Example
Mature: sublimation	Channeling aggression into competitive sport
Mature: humor / altruism	Using humor to cope; helping others to manage one's own pain
Neurotic: repression	Unconsciously keeping distressing memories out of awareness
Neurotic: displacement	Yelling at family after a conflict with the boss
Neurotic: reaction formation	Being overly kind to someone you resent
Neurotic: intellectualization	Discussing a diagnosis in clinical terms to avoid the feeling
Immature: projection	Attributing your own anger to someone else
Immature: denial	Refusing to accept a terminal diagnosis
Immature: splitting	Seeing others as all-good or all-bad (common in BPD)
Immature: acting out	Expressing distress through behavior instead of words

Cognitive distortions (+ how to restructure)

Distortion	Example → restructure
All-or-nothing	"If it's not perfect, I failed" → look for the middle ground
Catastrophizing	"This will be a total disaster" → examine the actual evidence/odds
Overgeneralization	"This always happens to me" → name the specific instance
Mind reading	"They think I'm incompetent" → check the evidence; ask
Emotional reasoning	"I feel worthless, so I am" → separate feeling from fact
Should statements	"I should always cope" → replace with preference, not demand
Personalization	"It's my fault they're upset" → map the shared causes