QuikTest Analysis

Extreme Elevation of Anxiety and Depression Scores

By Dr. Robert Tippie, M. Div, PhD

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QuikTest Analysis

Extreme Elevation of Anxiety and Depression Scores

By Dr. Robert Tippie, M. Div, PhD

Why This Article?

Why am I writing this article? Because in our day extreme elevations in anxiety and depression have become an extraordinarily critical issue. In fact, the number of incidents of both anxiety and depression are increasing at an alarming rate. Individuals are rapidly reaching a point wherein daily functionality is being affected – at least in some cases. Medication is becoming commonplace[1] to curb the affective dysfunctions of both anxiety and depression. Individuals sometimes feel unable to cope with some routine functions of life. Other functions are simply being ignored. Medications may be a "necessarily evil" to curtail significant anxiety and/or depression. We will discuss those issues at great length here in this article and in many other places.

Financial issues weigh heavily on the increase of anxiety and depression, but financial issues are not the sole reason for the problems. Relationship issues are a substantial and contributing factor. The divorce rate in America is exceedingly high.[2] Other complicating factors are also present.

[1] This especially includes Xanax as the medical doctor's drug of choice. Other articles in this series will discuss whether or not this is the optimal drug of choice for anxiety sufferers. There may be more effective drug choices that the doctor is reluctant to prescribe, but those drugs may be safer and more effective in specific anxiety situations.

[2] The reason for the elevation in the divorce rate is questionable and there are many opinions why it is so elevated. Many divorces may be related to complex "life stressors" including job loss, under-employment, general economic conditions, and the change in social acumens that related to the nuclear family. These may be a combination of everything or they may be a single factor.

One recent study from the APA (the American Psychological Association) indicated that 2 out of 3 individuals self-reported that they were suffering from "extreme anxiety."[3] That's 66% of all people! That level of anxiety itself will weigh heavily over time on the status of relationships in general and on the ability of an individual to effectively function in society. In fact, that degree of anxiety will affect society itself at some time in the future.

Many people go stumbling through life with an enormous stress load on their shoulders. They often suffer from panic attacks and other significant anxiety syndromes. Many times, the anxiety can become debilitating. At the same time, they put on their makeup and walk out into the world as if nothing is wrong. Ignoring anxiety and its symptoms is one of the worst things that a person can do.

This level of anxiety can only occur for a short period of time before there is a significant effect in the life of that individual. At some time, they will be disabled both occupationally and socially. People make every attempt to cover up the fact that inside they are a churning mess. In fact, there are times when those individuals feel as if they are about to lose control of themselves.[4] Somehow, they pull it all back together, blinding themselves to the realities that brought about their problems to begin with.

The occurrence of extraordinarily elevated anxiety and/or depression can't go on forever. Yet, the society in which we live is structured in such a way that anxiety and depression will continue to escalate.[5] The amount of distress that individuals feel now will be paled by the amount of distress that they feel in a few short years. The issue of personal and emotional crisis will eventually reach a "critical mass" when all of these problems become public health issues. At that point, it will be too late to address their natural reversal on personal levels. At that point, anxiety and depression will become an official national crisis.

Our nation has truly entered a critical point from which there seems to be no logical return. Logical human beings cannot resolve the issues that they face. They are essentially trapped. As time goes on, the stressors brought about by the issues that they have long ignored will stare them in the face and they will engage in an emotional and a psychological "crisis event" that they will not be able to ignore.

At the current time, the seasoned and well-trained pastoral agent can perform the most effective work possible in helping individuals reduce both anxiety and depression. The trained pastoral agent is as capable as – or even more capable than – other psychological care workers. The "normal" pastor may not feel they have such capabilities, yet the capabilities are there, none the

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[3] It is not clear what the critical reason for the elevation in extreme anxiety was according to this study. Nevertheless, no matter what the critical reason was, this is a very significant number. It is unacceptable and does not bode well for the future since there appears to be no clear plan to relive symptomology associated with their massive increase in anxiety. This increase in anxiety will no doubt accentuate other areas of life and cause other significant social issues.

[4] Clinically speaking, this may be a real possibility of a person drifting toward a total emotional breakdown. This may include psychotic behaviors in the short-term or in the long-term. These issues become psychiatric in nature and are not easily resolved, if they are ever completely resolved at all.

[5] The author is under the opinion that the world continues to move at a faster and faster pace. That pace stretches individuals and families financially, socially, relationally and escalates the amount of stress that we experience on a daily basis. There is no longer any "down time" in society. There is no time to just "sit on the porch swing" and talk about what happened during the week. Often, people are doing two or three things at a time – listening to music, reading the paper, and casually working through some project from work in their heads. As humans, we are not structured to function in this capacity without reaching overload. We, in my opinion, are approaching that "critical mass."

less. With a little training and the acquisition of some knowledge, the pastoral agent can affect the greatest good for the most people – even more good than the trained psychologist.

Why do I say this? Because the pastoral agent has a substantial audience of people who know him or her. They usually trust the pastor. The pastor has access to those individuals on a weekly basis. With a little training, the pastoral agent can conduct classes – real classes – that will help individuals who are suffering. Aiding people in both the reduction of anxiety and depression does not take a "rocket scientist," it simply takes someone with a little knowledge. We intend to give you that knowledge throughout these courses.

It cannot be over-stressed that the pastoral agent is the key to recovery in almost all instances wherein emotional and psychological crisis occurs. While the medical doctor and the clinical licensed counselor/therapist/psychologist may play auxiliary roles, the pastoral agent must play an essential role if we are to survive through this flood of negative social emotions. Without a pastoral agent engaging in this key role individuals suffering in the coming days will not receive the comprehensive help that they need and the possibility of the problem becoming a self-perpetuating one is very high.

So essential is the pastoral role in our current crisis that it is not possible for a person with extraordinary elevations of anxiety and/or depression to receive complete healing without the aid of pastoral counseling. The reader will understand the complete pastoral role further on in this article. The pastoral role is critical – just as critical as that of the medical doctor and the psychologist, if one is even needed. The pastoral role is not optional and should not be diminished to any degree.[6]

Any responsible counselor – pastoral or otherwise – must be aware of the critical points and the dangers associated with elevations in both anxiety and depression. Some recent studies have indicated that well more than half of all Americans are suffering from "extreme anxiety." This is a critical issue – even a catastrophic issue. If you counsel people at all, you will encounter anxiety issues on a very regular basis.

Every counselor needs to know how serious an individual's anxiety and/or depression level is. The counselor needs to know their responsibilities and their limitations. Quick response is the key to helping individuals already overcome with anxiety and/or depression. Especially for pastoral counselors, they need to know their unique responsibilities even in light of the fact that pastoral counselors might refer individuals to an outside counseling agency. I don't believe that the pastoral responsibility is finished once a pastor refers an individual to an outside agency. We will discuss that issue later in this article.

Please read this article carefully. It appears that there is a "plague" of sorts happening in our society. Both anxiety and depression are becoming raging fires in all walks of life – from the tailored businessman to the homeless. The pastoral counselor can (and should) play an increasing role in dealing with these issues. The moral, ethical and theological issues that the client suffers from when they experience anxiety and depression must be answered by a pastoral agent. The pastoral agent is the only one who can make sense of those issues, ultimately.

Although you as a pastoral agent may refer most extreme cases to an outside counseling center, you may wish to rethink your continued involvement, especially secondarily as a pastoral agent.

[6] It is unfortunate that many medical doctors exclude consideration of trained pastoral agents as viable psychological therapists. This is a significant error on the part of the medical doctor.

Individuals with extremely elevated anxiety and depression levels don't have time to wait months for relief from traditional therapy. Something unfortunate may indeed happen to the client long before the 50-minute weekly counseling sessions begin to have an affect. Among the most important issues that a client often needs answers to are issues related to religious and theological matters. You – like it or not – may be on the frontline of ministering to these individuals. Hopefully, this article will give you some pointers about dealing with these issues.

What Are Elevated Scores?

[The following discussion relates to both anxiety scores and depression scores generally as measured on QuikTest. QuikTest should become a tool that is used each time that a pastoral agent encounters a person with elevated anxiety and/or depression. The more you use the tool, the more accurately you will determine the depth and consistency of the anxiety and depression issues. After five administrations to a single individual, the amount of information that you receive from the visual representation of QuikTest will triple. Additional components appear on the screen. There is a wealth of information that is critical to understanding the condition of the individual. Some of this information may be life-saving.[7]]

QuikTest was the first test ever created by MARET. It has been around since 1988 – over two decades now. Even though it only contains 37 test items, QuikTest packs a powerful punch when it is used correctly. There is so much data packed in its three simple scales, especially when it is re-administered to an individual on a regular basis. No counselor should ever encounter an individual in crisis without using QuikTest. Once it has been administered to the same individual five times, the amount of data produced by the report triples.

QuikTest is a standardized test. The score of 100 is the "average" score. The standard deviation[8] is set at 10. The results of the QuikTest assessment have been standardized and normalized and they are parametric. That means that there are as many scores that fall on the lower side of 100 as there are that fall on the upper side of the 100 score.

A reasonable "normal" scoring range is between 90 and 110 – one standard deviation above and one standard deviation below the mean of 100. Approximately 2 out of 3 people will score within that range.[9] Scores in that range should not be considered as a problem, unless there are other indications from the client.

Scores above 115 and below 120 usually indicate *Anxiety* or *Depression* or *Personal Safety* scores that are usually tolerable by the individual. This, however, is dependant on the temperament of the individual and on other life situations. Some people can take more than others and other life situations may complicate the stress.

Prolonged scores in the range of 120 may become problematic for some people. This is, after all, two full standard deviations above the mean. Undoubtedly, prolonged scores in or above the range of 120 will present significant emotional and psychological distress to the individual. Significant development of *Axis I Disorder*s are not uncommon at this level. This is especially true for some cases wherein other contributing and complex life situations exist. These scores may present some daily difficulties in functioning, although they should not shut down the ability

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[7] As a further note, there is no reason whatsoever that a medical doctor who routinely sees patients for anxiety and depressive symptoms could not use QuikTest as an effective measurement of anxiety and depression.
[8] For those who know what a standard deviation is.
[9] One standard deviation on either side of the mean (average) score.

of an individual to function completely. Increased aggravation over "small matters," forgetfulness, and significant fatigue are not uncommon. Loss of concentration is often reported.

Scores that approach or exceed 130 are critical for the vast majority of all individuals. A score at or in excess of 130 is three standard deviations above the norm of 100. This is clearly unacceptable over any period of time. Everything possible must be done to reduce anxiety and/or depression scores below these levels as quickly as possible. It may be possible that an individual needs immediate medical attention – even on an emergency basis, depending on the *Personal Safety* score. An individual with prolonged scores in the range of 130 and above may display symptoms and behaviors that are destructive, maladaptive and significantly dysfunctional. Psychosis may be a real possibility, even if it is a *Brief Psychotic Reaction*. Prolonged scores in and above the range of 130 might bring about *Delusional Disorder*. Spontaneous suicide cannot be ruled out, especially if the *Personal Safety* Score is elevated above 125 and the individual has longitudinal indications previously of being in that range.[10]

A score in this range demands immediate action to alleviate the factors and/or the symptomology that are causing the elevated anxiety and/or depression. There is no time to waste and action must be taken immediately. There is simply no time to wait for a weekly therapeutic and a regularly scheduled appointment with a therapist or a psychologist.[11] It is also appropriate for an individual with a score in this range to visit their medical doctor as quickly as possible to ensure that there are no medical reasons for the elevation in scores. Depending on the specific situation – especially if it is a crisis – there may be a reason for immediate medical attention via an ambulance, especially if it is believed that 1) life is in danger due to suicide, 2) if there is marked disorientation due to psychotic symptoms, or, 3) if there are signs of physiological medical emergency.

How Critical Are Elevated Scores?

Any score above 120 for a prolonged period of time (say, a month or more continuously) will present unpleasant emotional and psychological issues that will begin to wear down the individual.[12] There is a strong possibility that scores in this range will also cause some amount of disruption of daily activities. Scores in this range routinely disrupt family life – they "trouble" life and make it more complicated than it ought to be. Panic attacks are somewhat common based on the temperament of the individual. There is also a possibility of some early signs of other *Axis I Disorders,* although it is unlikely that these will be extreme.[13] The possibility of psychosis is minimal at this level. Physical ailments might also present themselves (especially stomach issues, aches and pains in the joints, and sleep disturbances). *Mood Disorders* are not uncommon and a *Major Depressive Episode* is certainly not out of the question.

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[10] A longitudinal *Personal Safety* score (the "static" mean score) at or above 125 when the *Anxiety* or *Depression* (especially *Depression*) score "spikes" above 130 should cause immediate concern for the therapist. The therapist must be absolutely certain that the individual is of no harm to themselves prior to releasing them from the office. All numerical scores from the tests would indicate otherwise. These are critical scores. [A longitudinal score is a score that has accumulated over a minimum of five administrations of QuikTest. It is the mean score that has accumulated over time.]

[11] This is most certainly true if the nearest appointment that can be made is two weeks away. That is not acceptable and other options will need to be taken. One suggestion is that a medical doctor accumulate a listing of reliable and effective pastoral agents that can aid in immediate crisis events, when needed.

[12] Many "armchair" psychologists say that America is a depressed nation. I disagree. America is a worn out nation – worn out because their levels of anxiety and depression have been elevated for so long that they have just become tired. They are worn out. They are exhausted. America doesn't suffer from corporate *Major Depression*. America suffers from corporate *Dysthymia*.

[13] But one never knows for sure….

This fact is magnified when the scoring approaches or exceeds the score of 130 for *Anxiety*, *Depression* or *Personal Safety*. It cannot be overstressed that a score in the range of 130 or above is an extremely critical score. The therapist must do everything possible to reduce this score below the 120 range as quickly as possible. It is not recommended that the client be allowed to continue in this situation for many days. The situation is critical enough that it must be resolved in a matter of days or even hours. This applies for *Anxiety* scores for *Depression* scores, and for *Personal Safety* scores. The *Personal Safety* scores are even more accentuated since these scores may indicate an ability to harm oneself.

What Should be Done with Elevated Scores Immediately?

Probably the most important first step that you can take when you encounter a score in the 130 range is to make some attempt to determine why the score is elevated in that range. There are a number of factors that can elevate both depression and anxiety to this level. Understanding why the level is elevated to this degree is critical to finding a resolution for the issue.

Here are the primary reasons that an individual's score may be elevated in this range:

- *A physiological problem that has caused a chemical imbalance*. This is rather low on the list of primary reasons that cause such elevations in anxiety and depression – but it is a possibility. For that reason, the individual should engage in a medical examination from a medical doctor to make sure that the anxiety and/or depression is not being caused by a purely physiological issue. Whenever a person's anxiety and/or depression level is at or above 130, the therapist (including the pastoral agent) should always recommend a visit to a medical doctor. When an individual will not go to the medical doctor it is *critically important* for the therapist to notate in the individual's chart that they have been not been compliant regarding the issue of seeing a medical doctor. A lack of recording such information may come back to "haunt" the therapist, should something medical happen to the client. This may result in litigation if there is no documentation on the part of the therapist.
- *Sudden trauma may also cause extreme elevations in anxiety and/or depression*. Such sudden traumatic events might include things like a very traumatic car accident, the death of a loved one, loss of a job, witnessing another person's death or serious injury, or some other extremely traumatic event. These things should be recorded by the therapist for further discussion, when appropriate. *Posttraumatic Stress Syndrome* is a real possibility in many of these cases and every thing should be done to prevent it from occurring.
- *Prolonged negative life change may cause extreme elevation of anxiety and/or depression*. This is the most difficult of all situations to counsel for a number of reasons. We will discuss more regarding this issue under the heading of ***Your Responsibility***. In America today, this is by far the most significant reason for elevated anxiety and depression levels. And, by far, the issue of financial distress is among the greatest of all reasons for that elevation in anxiety and depression.

There are different ways to deal with elevated scores based on the reason that the score is elevated. Below we will survey the primary and secondary means of dealing with each of the three categories of elevated scores. Pastoral involvement (from my opinion) is necessitated at all three levels. The reason that I continuously stress that pastoral involvement is so important is because most of these issues involve at least some moral issues, ethical issues, or spiritual issues.

It is only the trained pastoral agent that can accurately deal with moral, ethical and theological issues. (There are other significant reasons for pastoral involvement, also.)[14]

There is another reason that pastoral involvement is mandated at all three levels. Usually when an individual is recommended to an outside counseling agency for therapy, that counseling will be scheduled on a weekly basis that includes only about 50 minutes of real time in actual therapy.[15] In the case of extreme elevation of depression and/or anxiety that time frame is simply unrealistic and the alleviation of depressive and/or anxiety symptoms does not occur rapidly enough. In some extreme cases, there are two sessions (of 50-minutes each) scheduled during a week. That is not enough. A vast majority of clients become discouraged due to lack or progress and discontinue therapy – choosing to living in their misery. Many go once to the "high priced" therapist and never return.[16]

In fact, this can actually cause the situation to worsen. Domestic violence, drug addiction and abuse, fighting, arrests, and most other things seen on "Cops" are a real possibility. (Keep those camera rolling!) The individual often becomes disillusioned with the slow progress of therapy. Most individuals at this level of crisis need more intensive help than 50 minutes a week. That is, quite frankly a joke. Psychologists cannot, and will not, fill these obligations due to the expense involved. They make the"big bucks," remember. This is where the pastoral agent – well trained through systematic education can become a big help. The only issue is whether or not they believe that they are called to minister to these types of situations.

A significant number of first-time visitors to psychologists never return because they get absolutely disillusioned after the first session. They need immediate help for real, substantial pain that is eating their guts out; and, they just get platitudes: "blah, blah, blah…blah, blah,… you know what I mean, right? Blah, blah , blah… Oh, our time it up. That will be the equivalent of a new car, thank you…Leave the money on the table, see ya next week."

This "nominal" method of psychotherapy is so ineffective that it might borderline on danger— or at least some sort of malpractice. It has little concern for the patient. The primary concern is on the accumulation of wealth (and lot of it). The welfare of the client, if he or she is considered at all, is way down on the list. The "hillbilly" pastor (p[lease forgive the colloquialism) missing most teeth can do a much batten job for one reason: HE CARES. And, that coupled with some real education can make him a powerhouse that shames the trained clinical agent. He already cares. We can give his the education.

It is care and concern for money and things that the non--conscientious therapist will learn to deal with new clients in the usual manner. Although it might be most costly, there is no reason that a psychotherapist should not see a new client on a three-hour secession for the first time: 1) *One*

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[14] One of the reasons that I believe that pastors should be trained to counsel more extensively than they previously have is because I believe very strongly that we are entering a time of crisis in our nation wherein there simply will not be enough trained psychologists to go around. Furthermore, I am not too sure how many of those psychologists are willing to work on a pastor's salary.

[15] And, of course, the first week is always a "get to know you" session. That means that absolutely nothing is accomplished in counseling in the first two weeks. The first week is filled with fluff: "So, tell me a little about yourself…." This is unfortunate (I guess it has to be done), and it leaves the client with the same pain that they walked in the door with. The expert psychologist plans for two hours the first session. The first, is the "get tofs know you" session, and the second starts the actual work.

[16] Admittedly, the pastoral agent who is going to take on an additional load of counseling will need some additional training. It is the purpose of the ***MARET Premium Services*** website to give a pastoral agent expertise training in areas that they will need. This training is being administered and monitored by an individual with both a Master's in Divinity and a PhD in Counseling Psychology.

hour to accumulate the information that is needed on the client (name, address, shoe size, etc.), and, 2) *one hour* to get a general idea – global concept of the person's problems, and, 3) *one hour* to really get to the "guts" of the issue. This would indicate a completely consciousness therapist who understands the needs of the client – not just that he needs to schedule life "by the hour" and collect as many adult toys as possible; boats, cars, planes. etc.)

Furthermore, except for the case of a purely physiological incident, the individual will likely have significant moral, ethical, and theological confusions and questions that need to be addressed. While some outside therapists may be able to divert answers related to these issues, it takes a trained theological expert (e.g. a pastor agent) to deal with these very hard questions[17] that a client will have.[18] It may be important to the client for the pastoral agent to be answering those questions from their own comfort level.[19] Those questions will likely be at the core of the increased anxiety and/or depression and maybe even the perpetuation of the anxiety and depression. Helping an individual resolve those issues may indeed lessen the amount of anxiety and depression that they are experiencing. You, as a pastoral agent, become a key player in the reduction of both anxiety and depression by giving an individual answers to questions that perplex them. Thus, when you refer a client to an outside therapist your job is not over. There will be questions that will continue to perplex the client, even when they are seeing a psychotherapist.[20]

Dealing with Sudden Trauma

Sudden trauma demands answers and almost immediate action. Those answers must be real and they must fit within the real-life "world" of the individual. No "canned" answers, no fake answers – and, no pats on the back – will satisfy the individual who has suffered an extreme trauma. Likely they will be in a state of hypoventilation or even in panic attack. They may lose control of themselves completely. They may enter a fetal position on the floor – yelling and screaming out of control. And, I don't care what you do, you won't be able to stop them in most instances – given them some distance and let them think things through and make sure that they, their people and their surroundings are safe. Don't over control. Do not touch them unless they specifically ask for you to touch term.

Let them get it out. Hold them after it's over. Questions almost always make their way back to God and why God would allow certain things to happen. It is critical – even essential – that you make sense of these questions immediately (even before the details of the trauma, in some

[17] Just as completely as it takes a psychiatrist to deal with a complex mix of medications in the case of a serious depressive or anxiety-related situation.
[18] It is not logical for the psychologist, the licensed counselor, or any other trained psychological care worker to deal with these issues. They are simply not capable of answering the real questions that the client has. This will leave the client with significant "holes" in their healing process and the holes are the result of the psychological or other psychological care worker not engaging a training pastoral agent. Biases against such individuals are illogical and unethical. It would be wise for any medical doctor, or a psychological care worker or any type to maintain a listed of trusted pastoral agencies whom they have personally interviewed. Ignoring this facet of human existence is naïve.
[19] In other words (to be frank) a strong Baptist will not accept the theological or moral "ramblings" of a secular psychologist. The individual will probably be skeptical of the psychologist to begin with, but the committed Baptist will not accept the moral, ethical, or theological statements of the psychologist. This is a reality that must be understood and it must be confronted and dealt with. The client's welfare is most important and sending the client to a substandard agent to deal with moral, ethical and theological issues will probably result in the client ceasing therapy on the first or second session
[20] There may be a program that can be piloted in some communities engaging health care workers, psychologists and pastoral agents. All three of these can work together to do what they do best for the welfare of the client.

cases).[21] Make sure that a trained pastoral agent is on site at all times to answer questions, to console people and to help in any way possible. This is no other option!

While a trained clinical psychological therapist may be able to give some standardized answers[22] to theological questions – answers that the trained psychologist has been "programmed" to administer – the individual suffering from their real trauma knows that the clinical psychological worker is not an expert in these things. They know that the words of the psychologist are just a cover up and that they are not real answers. Thus, the answers are often written off by the individual leading to discouragement, at best. What the individual needs at this point is a "God expert" – a pastoral care worker. It seems that clients are more likely to accept answers from pastoral agents regarding these issues of ultimacy rather than from anyone else.[23]

Without answers to these ultimate questions, the individual may indeed become cynical, they may become delusional, and – depending on the severity of the loss – they may exhibit characteristics of psychosis. They may become bitter or even enraged. They may learn to doubt religious and theological realities that they have accepted for years. This occurrence further deepens guilt and increases (and more deeply embeds) both depression and anxiety. At the point that trauma is occurring, the pastoral agent is critical in the very beginning stages of the resolution of anxiety and depression.[24] This action often sets the stage for future healing from the trauma (depending on the trauma).[25]

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[21] For nine years I worked as a crisis chaplain in a Level #1 Trauma Hospital Emergency Room. Believe me, I saw a number of tragic cases come through the door – cases wherein I knew the individual in the ambulance had no chance of surviving. I saw everything from old folks to infant children 10 months old dead on arrival. The most overwhelming question asked by the survivors was not "what happened?" The most overwhelming question was "Why did God let this happen." The hospital system that I worked with understood that this was the most predominant question asked by survivors. That's why they made sure that there was always a trained spiritual advisor and a chaplain "on board" when there was a crisis. Doctors couldn't answer those questions. In fact, I often dealt with the doctors themselves answering the same questions in the times of most extreme trauma. Everyone from medical doctors to clergy should understand that in causes of extreme and sudden trauma people want to know answers "ultimate questions." They don't care about the facts of the case until later. They want to talk about God. The doctor who ignores this is not doing justice to their patient.

[22] "Blah, blah, blah…"

[23] With these issues, there is an increasing risk of significant (and potentially life-altering) emotional and psychological reactions. For example, I knew of one individual who suddenly lost a loved one. She did not have the advantage of pastoral care. For years she lived with the delusion that the dead friend was simply "on vacation" (a *Delusional Disorder*). She never came to grips with the fact that the individual was dead and gone. Proper emotional care from a trained and expert pastoral agent would have probably prevented that *Delusional Disorder*.

[24] Many of these life changes are out of the immediate nine-year period of time that I worked in the ER, however, I continuously witnessed the effects on both victims and on their loved ones. After some time, the medical staff that I worked with admitted that what I did in the ER (often while medical procedures were occurring) was essential. There was no medical doctor that would discuss the situation of a patient after treatment without me being present in the room with the loved ones – even if everything was relatively OK. The doctors began to realize that people had significant spiritual "sides" to them that needed as much attention as the physical issues they were suffering. Every ER and every doctor should realize this – even if the doctor feels that medication is "king" – in the mind of the patient that is most certainly not always the case.

[25] I must admit that over my nine-years of experience as an ER Crisis Chaplain, there were a few cases wherein my presence only helped sooth the immediate situation. I am quite confident that years of therapy could not resolve some of the trauma that survivors had witnessed. One case in particular (some facts have been changed to protect the identity of individuals) involved the suicide of a seven-year old child. That suicide was apparently brought on by morbid and prolonged sexual abuse of the child. I am confident that no amount of therapy would ever resolve the anguish, the depression, and the horror that that mother suffered on a daily basis. While I spent hours in the ER counseling room with her, while I spoke the "right words" to her, while I showed my compassion to her by showing up at her daughter's wake, there is nothing that will ever take away the pain of prolonged child sexual abuse. That mother was scarred forever without hope of ever becoming "normal" again. Even some of the medical staff suffered for weeks (off and on) over the incident. I would take them in counseling rooms where they would ask me the troubling and ever-so difficult questions, "Why?"

Dealing with Prolonged Life Change

Prolonged life change occurs when significant life changes[26] occur in an individual's life. These effects are usually felt as brain chemistry deteriorates and causes significant negative imbalances.[27] Effects are felt over a longer period of time since the effects are more prolonged. It is almost like trauma[28] in slow motion. This, undoubtedly, is a far worse situation than a sudden trauma. When a sudden trauma occurs, the trauma can be "laid on the table" and the pieces can be sorted out. The counselor can help the individual deal with each of the pieces. And, moreover, a group therapist can do so rather quickly.

Unfortunately, in the case of a prolonged life change, the pieces are not usually as clearly defined. That means that it will take much longer to sort through those pieces. In fact, there may not be distinct pieces at all – only a mess that now calls itself life. There is a good possibility that therapy at this level will take some time. In some cases, therapy will be minimally or completely non-effective. The pastoral agent should be well-trained in dealing with these issues since they will see a number of these cases throughout their career.[29]

It is the pastoral duty to help an individual lay all of these components on the table; to help them sort through everything. The pastoral agent needs to find the most emotionally charged components of the life change and to help the individual work toward some resolution that is acceptable to deal with those unfortunate components.[30] Often these elements are moral and ethical at their core. They are almost always religious and theological. Those issues simply cannot be dealt with appropriately by a trained and licensed therapist or a psychologist. It is time for pastoral therapists to "step up to the plate" and to begin dealing with issues that are purely pastoral in nature – as difficult as those issues are.[31]

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[26] Marriage, divorce, children moving out of the house, death of a loved one, sale of a house, purchase of a house, etc.

[27] This may be one legitimate use of a n SSRI, although the author is still not "sold on" SSRIs since their immediate mechanism of neurotransmitter interaction is understood.

[28] Discussed above.

[29] These cases will continue to increase in number as the insurance industry disintegrates to the point where they no longer cover significant psychological issues. When that occurs, the pastoral agent has two choices: Pick of the slack left by the imploding insurance industry or let clients suffer through their pain. The latter, in my opinion, is not "pastoral" in nature and should never be an option. ***MARET Premium Services*** is making an incredible sacrifice to offer free and unrestricted training and education to the pastor to help them deal with significant psychological and emotional issues. Take advantage of it. You will need it more rapidly than you think you will. It is also imperative that the pastoral agent obtain a copy of the DSM-IV-TR and learn how to read it. That will be part of the educational services that we will be offering.

[30] There is a certain "mystique" about advances psychological training. Pastors assume that trained and licensed psychologists can solve all of the world's problems in a period of less than five minutes. They assume that no matter what type of psychological or emotional case "walks through the door," the psychologist immediately has a "handle" on it. They have a course of actual that will solve the issue. I can tell you from two decades of experience that that is simply not the case. I have had many conversations with trained, licensed psychologists who have called to say, "What in the world would you do with this case? I have no clue." Psychologists routinely exhibit the same puzzled and muddied solutions that the trained pastor does. Furthermore, many of them don't have a moral and ethical background to consult. They are on their own. Remember this carefully, a well-trained and seasoned pastoral therapist is as good (in some situations) as any psychologist 00 even those PHD is not after them. Care and true concern go along way toward curing an individual. Cold and calculated educational protocols are usually dismissed by the client. There is one caveat to this statement. In the case wherein an individual is in "trouble" due to psychosis, the trained professional can perform in ways that the pastoral agent may not be able to. We intend to give the trained pastoral agent clear and unmistakable indications of psychotic behavior so that they know when to call in the "big dogs."

[31] For that reason we have decided to provide you with expert training from a PhD in psychological. Hopefully, the information presented in these courses will aid you in the counseling of individuals who are in dire need of your services.

This will take some time for pastors to learn what they need to learn. It will also take some effort. Furthermore, it will take additional training on the part of the pastoral therapist.[32] The therapy that most clients need will not function well within the context of 50-minuite sessions once per week. That is simply not enough. Using that methodology, the cure for the psychological issue will take months. The client doesn't have months, the client may only have days, hours – before they degenerate into a condition that will take months to recover from (if recovery is even possible).

Most clients who are in extreme crisis only have a few weeks to begin to see light at the end of the tunnel – at the most. Some acceptable stability needs to be restored as quickly as possible or the client may face catastrophic emotional and psychological damage. This is especially true when QuikTest scores are approaching the 130 level.[33] That damage may or may not be reversed easily and it may require psychiatric hospitalization. This is especially true if *Bipolar I Disorder* occurs or if other forms of engrained psychosis are indicated. Sometimes these issues become chronic and are not easily resolved without significant psychiatric intervention (including hospitalization and medications that are not advantageous, to say the least).

These issues need to be prevented prior to them happening. The pastoral agent – well trained through the ***MARET Premium Services*** will greatly aid in the recovery process. The ***MARET Counseling and Assessment Software Package*** is the most comprehensive counseling package on the market and can greatly aid the therapist – well trained through the ***MARET Premium Services*** – to understand the severity of the client's situations. If the medical doctor will legally confer with the therapist, there should be less of a reason for a catastrophic emotional or psychological event should occur.[34]

How Closely Should Elevated Scores be Checked Again?

The higher that a person's QuikTest score is in any area, the more often it should be checked. Checking the QuikTest score of an individual whose *Anxiety* score, *Depression* score, or *Personal Safety* score is above 125 is one of the most responsible things that a therapist can do on a regular basis[35]. Remember re-administration of all ***MARET Assessments*** is free. And, remember that administrations of five or more QuikTests give you significantly more information. Use QuikTest! In fact, abuse QuikTest!

It is the obligation of the therapist to determine if a high score was just a transient elevation or if it appears that the elevation is a static condition under which the individual lives constantly. It

[32] ***MARET Premium Services*** offers free training for a number of issues (six of them in all) training courses will allow a pastoral therapist to gain significant expertise in areas that they need to learn specific and advanced training for therapy.

[33] It would not be appropriate for the medical doctor who sees a number of patients regarding psychological issues and is willing to prescribe psychotropic medication to obtain a copy of the ***MARET Counseling and Assessment Software*** and to modify its use for their practice. The use of QuikTest alone would be worth the investment in the software package.

[34] It would also not be inappropriate for a medical doctor who sees a number of individuals with emotional and psychological issues to obtain a copy of the ***Counseling and Assessment Software***. The medical doctor can easily administer the QuikTest in a matter of minutes in the office and determine immediately the status of the client. This will certainly aid the medical doctor in prescribing appropriate medication for the client's needs.

[35] When a specific area score for any of the three areas – *Anxiety*, *Depression* or *Personal Safety* – is above 125– it is imperative for the therapist to check the score each time that they encounter the client. In fact, it would be wise on the part of the therapist to send a copy of the QuikTest test home with the client. The therapist should also send a number of copies of the answer sheet. The therapist should instruct the client to take the QuikTest as often as possible on paper. It might not even be unwise for the therapist to ask the client to record the time of day and the events that were transpiring during the test administration. This may aid the therapist in understanding if the anxiety/depression issues are situational or not.

might be a good idea to send a copy of QuikTest home with the client with a number of test answer sheets. It would not be unreasonable for the client to test themselves every day. Then, have the client fill out QuikTest again when they come into the office. The more information you have from QuikTest the more you will be able to see how consistent the client's score elevations are.[36]

Obviously, if the condition is transient – up one day and down the next – then the individual appears to have some control over the situation. They should still be administered QuikTest on a weekly basis. On the other hand, if the individual's *Anxiety*/*Depression*/*Personal Safety* score is consistently elevated every time that you check it, then there is a serious problem that needs to be addressed immediately. When an individual has a QuikTest score in the 130 range, it would be wise to obtain three different testings during a one-week period of time. Complete analysis of the multiple QuikTest graph should be undertaken very carefully.

It cannot be overstressed: A QuikTest score in the range of 130 for *Depression*, *Anxiety* or *Personal Safety* may not be allowed to stay in that range for any more than a few days without action to relieve that distress level. It is dangerous and the dangers are substantial. The individual with scores in this range must be given some solution or some resolution to their issue at the time of the first meeting – even if those are sort-term relief measures. They must be given some hope. Medication might be the first line of defense.

This individual cannot wait an entire week to be seen again regarding this issue. There is a possibility – if nothing changes – that their condition will be far worse in one week. It is unlikely – especially in the case of a prolonged negative life change – that very negative things will occur in the individual's life prior to the next scheduled meeting.

The Dangers of Prolonged Elevated Scores

Usually prolonged anxiety and prolonged depression often occur together. The therapist may find that one is slightly stronger and more consistent than the other.[37] But in all, the therapist will usually find that anxiety and depression elevate together. This is because they act together to attempt to regulate and normalize the state of the individual. Where anxiety causes panic, depressive symptoms attempt to calm that panic.

In the QuikTest range of 130 on any scale, the individual's physical state will begin to deteriorate after a number of weeks or even days. The individual will begin to develop a number of significant physical issues that may be transient (persisting) only as long as the elevation of the emotional state; or the individual may begin to develop serious physical and psychological ailments that might become permanent. *Axis I Disorders* will become apparent when the individual has suffered from these scores for a period of undetermined (but substantial) length. This will probably be weeks, but it may be a shorter period of time. *Delusional Disorder* is not

[36] Remember that when a client fills out the QuikTest assessment five or more times, the amount of information that is given to the therapist is tripled. Other informational articles explicitly explain all of the screens and scores associated with those additional scores in exhaustive detail. [In fact, this is part of the educational system associated with the QuikTest Course.] The therapist who experiences a client with elevated *Anxiety*, *Depression*, and/or *Personal Safety* scores and does not retest their client on a regular basis is acting irresponsibly. They are, essentially neglecting the welfare of their client. Once the ***Counseling and Assessment Software Package*** is purchased, use of the assessments is free. There is not reason not to retest individuals – especially when significant information may be obtained from multiple administrations of QuikTest that may save the life the of client.

[37] This will only be visible when the therapist has administered QuikTest five or more times. Complete information will be given in another document to detail the findings of multiple administrations of QuikTest.

uncommon, uncommon stress-related dysfunctions may present themselves, *Bipolar I* issues may arise. Some of these may be transient and others may become engrained in the personality of the individual. Extraordinary anger and aggression is not at all uncommon. *Panic Attacks* and the full development of *Panic Disorder* are not at all uncommon. *Agoraphobia* is another common ailment.[38]

As far as the physiological changes, for example, a person who has a blood sugar regulation problem and is currently being treated with medication might see their blood sugar skyrocket in a time of prolonged stress. If that stress is prolonged long enough, there might be a negative effect on their blood sugar balance that could lead toward the need to use insulin rather than just oral medication. In this case, it is unlikely that reduction of the stress generated from anxiety and depression will allow the individual to cease from using the insulin once the stressing event is past. The physical changes will have been made and there will likely be no reversal to previous non-stress physical states.

If depression levels are significantly elevated, there is a possibility that the person can become a recluse – locking themselves in one room and staying in bed all day. There is also a possibility from both anxiety and depression that the individual can cross over to psychotic episodes and symptomology. This is especially true if there is a co-morbid *Major Depressive Episode* and/or *Bipolar Disorder I.*

Those episodes will be dictated by a number of factors. Attempting to predict when and why an individual will break through the barrier of psychosis is nearly a useless effort. However, many counselors have been caught off guard by someone who seemed to be OK and suddenly "lost it." It must be understood that a score in or above the range of 130 is dangerous. Each individual will have their limits of how much constant stress and distress that they can take. When they can take no more, their emotional and psychological state unhinges from reality. This, in itself, is a defensive maneuver to "protect" the individual from the stark realities which they cannot cope with. Essentially, they create a new reality that is more plausible to them than the reality that is causing so much pain. That "new reality" maybe become permanent.

It is imperative that the counselor gain control of the individual's situation and give some amount of relief prior to the client experiencing any break from reality. Sometimes a break from reality is hard to recover from. Sometimes it does permanent damage. Sometimes it brings with it a whole new set of circumstances and problems and only complicates the issue. At the same time, there are often cases when an individual is not able to fully recover from a psychotic event. Most breaks from reality require hospitalization, which will likely include significant and adverse medication administered by a psychiatrist.

One of the most predominant complications associated with extreme elevations of anxiety and/or depression is the disruption of the sleep cycle. When the sleep cycle is disturbed, the client may more easily slip into more complex states of distress. Those states may include increased desires for suicide and death and more frequent tendencies to move toward transient or full blown psychosis. Sleep is essential during this time of crisis. Conferring with a medical doctor regarding methods that can bring about sound sleep is essential. In the case where suicide is a real potential, the individual should not be able to self-administer their own sleep medication or a medical

[38] The therapist must completely survey all ailments under the DSM-IV-TR heading of *Mood Disorders* and *Anxiety Disorders* to determine if the individual is suffering from any of those ailments. In the ***MARET Counseling and Assessment Software*** (version 2.2.96 and above) the ability to test for these DSM-IV-TR *Mood* and *Anxiety Disorders* is found in a template for the user.

doctor should only prescribe what can be safely considered as a non-lethal amount of a sleep agent even coupled with other psychotropic medications that might be combined with alcohol to create a synergistic effect. Suicidal ideations and sleep medication combined with alcohol is one of the most effective suicide events – especially if administered in the "proper" sequence (which can easily be located through an Internet search).

Another common disruption associated with elevation of anxiety and/or depression is eating disturbances. The client will either begin a pattern of binge eating (and, that will likely be junk) or the client will literally go days without eating at all. Both of these factors are not good – and, in fact, they are dangerous. They will likely cause metabolic changes that will be dangerous, if continued. The wise therapist will have the client maintain a diary of everything that the client eats so that it can be reviewed during sessions. That diary should be double-checked during therapy.

The Role of the Medical Doctor

A conscientious medical doctor should be critically concerned when an individual's anxiety and/or depression are elevated near or above 130 for any more than a very short period of time. This cannot be overstressed. With prolonged elevation of either factor, it is at this point that drug therapy must be considered. There are two different classes of drugs that a medical doctor may prescribe for these situations. In fact, they may prescribe both classes of drugs, depending on the situation.

As a side note, in the ***Forms*** section of ***MARET Premium Services*** on the website there is a release form that can be signed that will allow you, the pastoral agent, to have communication with the medical doctor. This release form must also be signed by the client in order to comply with Federal Regulations.

We highly suggest that you use that form and hopefully the medical doctor will open lines of communication with you so that the two of you can work together to bring down the levels of distress that the individual is suffering from. Knowledge from a qualified therapist is invaluable to a medical doctor when prescribing the proper medication to a client.

The two types of drugs that are common for these situations are:

- **SSRI-Type drugs**. These are longer acting drugs and they alter mood beginning after about two weeks. This, unfortunately, does not resolve the immediate and sometimes very severe crisis and the individual will continue to suffer elevated depression/anxiety until the drugs begin to have an affect on the client's emotional and psychological state. Thus, there may have to be some more immediate drug therapy that will bring about a substantial reduction in emotional and psychological discomfort immediately. When conferring with the medical doctor, it is also important to communicate with the doctor regarding the suicidal potential of the individual. In a large number of cases, suicidal individuals are not good candidates for SSRI-Type drugs since the drug may enhance suicidal ideation and may massively increase aggression (sometimes leading to domestic violence).
- **Benzodiazepines**. This is the second class of drugs that a doctor might prescribe. The most common two agents in this class are Xanax and Klonopin. Xanax is a rather short-acting medication that relieves anxiety. It only lasts about 2 to 4 hours in the blood stream and is best used for short term "bursts" of extreme anxiety. Klonopin, however,

acts on a much longer schedule. It usually has an effect on the person for 8 to 12 hours. The normal prescription dose is .5 milligrams but 1 milligram is not uncommon for extreme cases (depending on the client's body weight). One of the most unfortunate side effects of Klonopin is its ability to put the mind of the client in a fog. This is something that the client will need to learn to deal with. Driving may also be a problem with the 1 milligram dosage. This drug should allow for some significant reduction of anxiety symptoms (given the proper effective dosage) but will certainly not take away all anxiety. At best, it will numb the anxiety. As a side effect, this drug may also aid in sleeping if a dose is taken near bedtime. This is an "off label" use of the drug and Klonopin should not be prescribed as a sleeping agent.[39]

The client should discuss all of these drug options with their doctor. It would probably not be wise for a pastoral agent to entertain too much discussion regarding these drugs choices with the client prior to the client seeing a medical doctor. You, as a pastor, do not have the right to prescribe these drugs. Recommending drugs may be crossing the line in some States and might cause legal issues. The best choice is to obtain permission from the client to discuss their case with the doctor and to discuss drug use with the doctor directly. Listening to the doctor is one of the most key elements that you can do. The doctor knows the client best and you are simply providing information that will aid the doctor in their medication choices.

The pastor is warned that both Xanax and Klonopin[40] are habit-forming. They also cause a rather rapid tolerance in the body. That means that both may help the client considerably at first, but after a few weeks or months their good effects may begin to diminish. It is at that point that the client may choose to take twice the dosage to ensure that they get the same affect from the drug. The therapist should be aware of this possibility and should help the client to maintain the prescribed drug regiment listed on the prescription bottle. If the client feels that the drug substance is becoming less and less effective over time, then the client needs to discuss that issue with their medical doctor rather than to take matters into their own hands.

Attempting to deal with anxiety (especially) at the level of 130 (or above) on QuikTest without some medication is a very hard thing to do unless the anxiety levels can be brought under control within a matter of days through therapeutic techniques. This process should go on no longer than a week. The suffering will likely be too great and may cause some significant disability and dysfunctionality with the client. It cannot be over-stressed that an anxiety score approaching 130 is dangerous of an elevation that most people cannot tolerate for any more than a short period of time. Something has to change very rapidly.

The Role of an Outside Therapist

When an individual is referred to an outside therapist – a therapist outside of your office – you must recognize the function of that therapist. That therapist is not the complete and final solution

[39] As a side note, Klonopin may have a cumulative effect in the client. Thus, essentially after some time the client with "unintentionally" overdose on the drug. This may cause stupor, illogical communication, symptoms of extreme intoxication, and other strong effects. This intoxication may take some days to go away. The medical doctor should not immediately assume that an individual using Klonopin is suffering from an auto-overdose. The medical doctor (probably in the ER) should do a complex drug screening panel and should also conduct the minimum of a field screening for stroke. The effects of Klonopin auto-intoxication mimic other incidences which the medical doctor cannot and should not overlook without risking medical malpractice.

[40] Over time, Klonopin may also have some other adverse affects on the client including nearly consistent confusion, inability to perform simple tasks that they have been able to perm in the past (like typing rapidly), etc.) At the same time, when it has to be the "drug of choice" then it just simply has to be tolerated, if it can be.

to the problem. The purpose is also not to simply "hand off" the client to someone else (in most cases). Once the individual is handed over the therapist, your job as a pastoral agent may not be done. In fact, it should not be done.

The outside therapist only has a limited number of hours that they can spend on your client. In fact, the likely scenario will be that the therapist will schedule the individual for one session weekly (maybe two to begin with). Those sessions will be about 50 minutes long. An HMO co-pay will typically run about $20 but if there is no co-pay the client can expect to pay anywhere between $120 per hour and $250 per hour.

An individual suffering daily from the intense anxiety and depression as indicated by the QuikTest results will receive little or no immediate help from visiting a therapist on this type of time schedule. There simply will not be enough contact to rapidly lower the anxiety and depression levels. The client needs another advocate: That advocate is you – the pastoral agent. If you are not trained to deal with these issues, then you need to obtain that training "free" through the ***MARET Premium Services***.

The role of the outside therapist is to affect long-term change in the individual. That takes time. They usually don't do well with immediate crisis situations that may take hours per week (although there are a few that do). Time is something that this client does not have on their side. They need some type of anxiety and/or depression reduction immediately – within the next week or two weeks at the most. Without such relief there may be dire consequences.

So, in short, if the pastoral agent chooses to refer this individual to an outside counselor, the pastoral agent should not feel that they have fulfilled their pastoral duties to the client. You have not. There still remains much that you need to do and much that you can do to help the individual. You are the "point person" in this whole issue.

The outside therapist will uncover the underlying mechanisms that allowed the anxiety and/or depressive state to come about to begin with. That therapy will likely take months. The client does not have months to bring down their anxiety and/or depression scores. They have a matter of days – weeks at the very most.

Your Most Critical Role

That leaves the pastoral agent as the one who is in most constant contact with the individual who is suffering. Yes, you have a medical doctor who is monitoring the physiological state of the individual. That doctor may have given the individual some medication that is doing some amount of good in lessening the immediate psychological pain.

You may have also sent the individual off to a licensed psychological professional for longer-term treatment. That is probably a good choice since there may be some things in the individual's personality that need to be dealt with. The licensed clinical therapist or psychologist will be good at locating those things, addressing them, and hopefully correcting them for the future so that this psychic event doesn't happen again.

But let's talk about the "here and now." John Doe is suffering. In fact, he is suffering severely. There are actions that you can take as a pastoral counselor to aid John in his time of trouble. Without some consistent (and frequent) contact, John is likely to fall into a "hole" that absolutely no one wants him to fall into. He may become so depressive that he will become unresponsive to

life – he may spend all of his time in bed all day, every day. He may drift into psychosis. He may choose to become homeless. His family relationship structure may fall apart and he may be left alone. None of these are options that should be allowed to come about without some attempted intervention. You, as a pastoral agent, can obtain training that will greatly aid this individual. There is nothing "magic" about it.

Sadly, there is no one else that can intervene in this situation other than an agent like yourself. It's not the job of the medical doctor. And, the clinical therapist doesn't have the time to perform these duties. Actually, it's not the job of the clinician to do these things. You are the one on whom these duties fall. These are, essentially, pastoral duties.

We will cover a number of pastoral duties that you should be able to perform for the sake of John until he is well on the road to recovery. The amount of time that it will take to get John to the place where he is standing on his own is not known. That will be determined by a number of factors including your skills, the depth of his problems, and his reaction to all of the care that he is given.

Here are some concrete things that you can do. Remember, this is a crisis and without some type of significant intervention this individual will likely fare far worse than need be. It is your choice – obtain the training to deal with the situations or let the person suffer through substandard care.

Maintenance

Maintenance means maintaining contact with John Doe to make sure that he is taking his medication, to ask how he is feeling, and to determine if there is an immediate crisis that needs to be addressed. This might be done by a daily phone call until such a time that the phone calls can become every other day, and after that less frequent.

Answering Theological Issues

John will likely have a significant number of moral, ethical, and theological questions. "Why would God let this happen to me?" You need to thoroughly and completely answer each and every one of them. In fact, the best thing that you can do is let John talk it all out. Let him get all of his thoughts out on the table. Take notes. Then start to answer his questions. These are questions that no other counselor can answer as capably as you can. Warning: Some of John's questions may be real "brain teasers." Remember that "pat" answers won't work. John will see those answers immediately and you will lose him. Try answering him with questions. That works many times.

Active Listening

When John is talking, you need to be actively listening. What is he really saying? What is he really asking? What is really hurting him?

Helping the Person make Daily Decisions

You need to determine what John needs to accomplish on a daily basis. You need to help him create a list of things that need to get done. You need to make him accountable to you and to himself to get those things done. Sometimes doing things is a partial solution to both anxiety and depression – although it is certainly not a cure-all.

Encouragement

John needs realistic encouragement. What is realistic encouragement? Realistic encouragement is encouragement that does not promise anything that cannot be fulfilled by John's actions or by your actions. It would not be wise to tell John that everything is going to be OK in the midst of a prolonged life change. You cannot guarantee that to John. Therefore, don't make that promise. Only encourage him with the facts that are in front of his face. Show him the good things that are in his life that he is probably overlooking. Show him the progress that he will make if he fulfills the list of things that he needs to do. Do not make "hopeful" promises for the future that neither he nor you can fulfill. This may cause a significant relapse and a loss of confidence in you as a therapist.

"Hope," while an encouraging and uplifting word for many people, is often a word that brings about anger in those who are in despair. Hope is something that doesn't exist in the future – and, may never will. It would not be a good idea to tell John to hold out some type of hope for the future. All John has in front of him are facts – and the facts are damned ugly. Don't say, "Oh, there's always hope for tomorrow." For John, there is not hope for tomorrow. There was no hope yesterday (and probably a string of calamities "prove" that). Don't use the word hope. Use action words that John can perform himself – if he chooses. That puts him in control of his situation to some degree – not to fateful hope.

Retesting with QuikTest

It cannot be stressed enough; you need QuikTest results on a very regular basis. There is no such thing as using QuikTest too much in a time of elevated *Anxiety*, *Depression* and *Personal Safety* scores. When scores approach 130 (or above on any scale), the individual should be tested a minimum of three times per week. They should be tested every time they enter your office. This amount of testing will immediately show you their average scores, standard deviations, and other factors including a scoring distribution for each test that has been taken. Other valuable statistics concerning the pattern of scoring for the future will also be provided. Use QuikTest as often as you can.[41]

Maintaining Contact with the Doctor and Therapist

When it is appropriate and permissible by written communication and permission with the medical doctor, maintain contact with both John's therapist and his medical doctor. Report both positive and negative developments to them. This is vital information for these professionals. Do not attempt to make contact with these professionals without written and signed permission from John Doe and from the professionals themselves since this violates existing Federal Laws.

However, it is permissible by law with a signed statement from John to allow communication with whomever he feels is beneficial in his case. For the medical doctor who will not speak with a pastoral agent, I believe that John may have some recourse in making sure that that communication does indeed happen. Such disavowal of communication – when John desires it – is irresponsible on the part of the medical doctor or the psychologist.

[41] The therapist is encouraged to use advanced methods of interpreting QuikTest once it has been administered five or more times. These results will be essential in determining the speed that the client is progressing and the direction that the client is going. If you as the therapist have established a relationship with the individual's medical doctor, then these results should also be shared with that doctor to determine the best routine possible for aid the client.

Additional Help with Depression and Anxiety

Other articles in the ***MARET Premium Series*** will enhance your skills dealing with both the issues of anxiety and depression. These articles will be posted under the ***Educational Heading***. You may also suggest specific articles to us at: maretsoftware@yahoo.com.

A Pastoral Resume for the Medical Doctor

Usually with extreme reluctance a medical doctor will confer with a pastoral agent. Most medical doctors do not consider pastoral agents as viable psychological agents due to the fact that they are not licensed by the State. Moreover, many medical doctors do not know exactly what pastors do other than stand up and struggle through a short homily each Sunday morning.

This is most unfortunate. Many pastors hold dual degrees – some in counseling, and some in social psychology. Others have similar advanced degrees. So, to assume that the pastor is nothing more than a person who speaks once a week is most certainly not true. There are many pastors who have been successfully counseling for many years. The long and short of it all is this: When a pastor consults you regarding a client and there is a signed release of information on the table from the client, don't automatically disregard that pastoral agent. Maybe the pastor holds a PhD in Psychology and he really knows what he's talking about. Maybe you need to listen. It might be to the benefit of your client.

Even without advanced degrees, many pastoral agents are experts at what they do. Many of them have been practicing for many years and have a vast amount of both education and experience. They also have first hand information regarding the client. Simply "writing off" the pastoral agent is not the wisest choice that a medical doctor can make.

For that reason, it would be reasonable for a pastoral agent to compile a comprehensive resume of the types of counseling that they have done, including the amount of time that they have in continuing education related to counseling. All education (including seminars) should be included on that resume. It would also be a good idea for the pastoral agent to compile a list of references that are appropriate for their expertise. This may help the medical doctor in accepting information from the pastoral agent when they are contacted concerning the situation of a particular client. When the release form is given to the medical doctor to allow the medical doctor and the pastoral agent to speak, the resume should be sent along as well.

When it all comes down to it, however, it will be the ultimate decision of the medical doctor whether or not they will accept the understandings of the pastoral agent. It will be the ultimate decision of the medical doctor if they will even give the pastoral therapist the "time of day." For a well-trained and expert pastoral agent, a rejection by a pastoral agent would be a significant loss for the client.

At that time, maybe it's time for the client to go doctor shopping…