Style Manual for the Series

Advances in Psychotherapy – Evidence-Based Practice

Danny Wedding (Series Editor)

This style manual is to be used for all volumes in the series ***Advances in Psychotherapy: Evidence-Based Practice*** dealing with a particular disorder or group of disorders. The basic objective of the series is to provide therapists with practical evidence- and research-based information in a "reader-friendly" manner. The books in the series are intended to be reference and educational works for psychotherapists, clinical psychologists, social workers and psychiatrists, as well as useful texts for students and trainees. These volumes are designed to be useful to these professionals in their daily practice and provide an ideal basis for practice-oriented continuing education. **It is important that all volumes in the series adhere to series guidelines on style and structure, so that when readers pick up a volume on a new topic / disorder they have the feeling that they already know where and how to find the information they are looking for.** All manuscripts will normally be reviewed and critiqued by at least two experts in the field, so we trust you will be prepared, if necessary, to amend content or structure in light of their comments.

Displayed Boxes: Whenever possible, the text should be structured to include easy-to-read lists or "pearls" that can be placed in highlighted boxes for clarity and emphasis.

Marginal Notes: A key word or phrase should be added in the margin of the text where each new or important topic (one or more paragraphs) is discussed. This marginal note should indicate the main conclusions/arguments, and summarize or point readers to the most salient information. The marginal notes are designed to help readers quickly orient themselves within the text when they are scanning for information.

Structure of the Volume

Each volume should be organized in the following chapters and sections.

1. Description [of the disorder/s] (20–35 manuscript pages)

1.1 Terminology
Name and code according to DSM-IV TR and ICD-10, as well as alternatives that may be used (e.g., earlier names) should be listed.

1.2 Definition
Definition / criteria according to DSM-IV TR and ICD-10 (including the research criteria), best summarized in a table.

1.3 Epidemiology
Brief description of the epidemiology (in table form if possible), including prevalence, incidence, and age / sex / ethnic group distribution if relevant. Brief notes suffice, which the practitioner may want to pass on to the patient.

1.4 Course and Prognosis

Discussion of the course and prognosis should include a brief description of the course of the disorder if untreated as well as with appropriate treatment.

1.5 Differential Diagnosis

The aim of this section is to give practitioners and therapists practical advice on what factors to watch for in order to differentiate the disorder from similar symptom patterns. For quick orientation, the name of each alternative diagnosis should be given in bold, followed by:

a) Signs / symptoms / syndromes / characteristics that both have in common
b) Characteristics that differ between the disorders This information should be placed in a box or table, with longer explanations – if needed – included in the text afterwards.

1.6 Comorbidities

This section deals with disorders that may be seen in association with the one being covered. The aim is to indicate to the practitioner what potential additional problems she or he should be on the lookout for. The presentation should be similar to that in Section 1.5.

1.7 Diagnostic Procedures and Documentation

Advice for the practitioner on suitable objective tests, diagnostic criteria, and diagnostic procedures: (a) for determining the severity of the disorder; and (b) for documenting the course of the disorder or treatment success. Precise information, including sources, should be provided.

2. Theories and Models of the Disorder (8–30 ms. pages)

This section should be based on results of the latest research; it is not intended to provide an overview of historically relevant models. The theory (or theories) and models presented should help the practitioner understand the individual patient's disorder (and if appropriate "explain" it to him/her) and what factors or conditions she or he needs to look for in the individual case. The models and theories should indicate the frameworks / case conceptions that are likely to be useful and appropriate in dealing with the individual patient, once a diagnosis has been made. If the current state of research means that it is appropriate to discuss more than one theory or model, then these should be presented one after the other so that the practitioner can examine and analyze her or his patient's case from each of the different theoretical viewpoints. Marginal notes and keywords should be added to indicate the model(s) or condition(s) being discussed at that point (e.g., "Dysfunctional cognition" or "Fear of anxiety").

3. Diagnosis and Treatment Indications (3–15 ms. pages)

Working within the framework(s) of the theories and models of the disorder described in the previous chapter, and based on etiological, clinical, outcome, and other empirical research, "rules" and guidance – as precise as possible – for the diagnostic and therapeutic decision-making process should be provided. These diagnostic guidelines should tell the practitioner what aspects require particular attention during the diagnosis (exploration, behavioral observations, psychophysiological studies, questionnaires, etc.). This will generally involve determining whether confirmatory signs and symptoms postulated by the previously described models are present.

If possible, you should also provide advice on the treatment indications (i.e., how to determine what is the most appropriate treatment). This will likely involve brief discussion of what methods have proven effective under what treatment conditions/settings and with which patients (what characteristics/groups) – the practitioner may have to determine whether they apply in the case of a particular patient. At the very least, you should attempt to provide guidance on what the primary aim of treatment should be and whether or how this depends on what conditions or factors.

If possible, present the “rule(s)” or criteria in a box; if appropriate, a “rule” can be preceded or followed by a more precise text description. It may be useful to illustrate the diagnostic steps and/or the decision-making process by means of a figure or flowchart.

4. Treatment (50–75 ms. pages)

This section should deal primarily with those methods that have been shown empirically to be effective for this particular disorder.

4.1 Methods of Treatment

Describe the method or methods of treatment in sufficient detail for a therapist/practitioner with some basic knowledge or training to be able to actually carry out the treatment based on the information presented in this section, without having to refer to other sources or literature. If necessary, complete bibliographic references where “beginners” can obtain an even more detailed description of the methods can be provided. Highlighted boxes and other graphical elements (e.g., flowcharts, tables) should be used to emphasize and illustrate the core elements of the methods and the steps the therapist/practitioner must take.

4.2 Mechanisms of Action

Summarize briefly current theories and research results about the mechanisms of action of the method(s) described in the previous section. This should not be a comprehensive review, but rather a compact summary of the method or methods. The relationship between the putative mechanism of action and the theories and models of the disorder (Chapter 2) should be explained.

4.3 Efficacy and Prognosis

Wherever possible, provide information on how effective the methods described in Section 4.1 (and their alternatives) are and the size of the effect, if necessary by estimating these retrospectively based on the published literature. Also state whether the efficacy was calculated based on a control group (which?) or a pre-post comparison. In addition, please provide details on efficacy, outcomes, time course, etc., as well as on failure rates and other unsatisfactory or unwanted outcomes. Furthermore, information on long-term outcomes and recurrence rates should be given. In this context, it is often appropriate to detail what measures can be taken to prevent recurrences (e.g., recommendations for booster sessions). Write this chapter so that it enables the practitioner to decide which method(s) is likely to produce the best results and should therefore be preferred.

4.4 Variations and Combinations of Methods

If variant forms of the methods described in the previous section exist, different means of carrying them out, or special forms for particular subpopulations (e.g., for children), these should be described here. Furthermore, provide advice on other forms of treatment that can or should be used in combination with the methods described. In the case of drug therapy, present details of the most widely used medications

(chemical and generic name, trade names, main effects, possible unwanted effects) should be presented in a displayed box.

4.5 Problems in Carrying out the Treatments

This section should detail problems that typically or relatively commonly occur when using the described treatment methods, and provide advice on how the practitioner should act or react in these cases. Examples include organization of suitable treatment settings or preconditions, dealing with issues of patient motivation, resistance, and compliance, and coping with problems in the patient/therapist relationship. Here, too, bolded text, boxes, etc., should be used to help readers find their way around the text.

4.6 Multicultural Issues

Use this section to comment on the ways in which different ethnic or cultural groups fit or don't fit the treatments you are proposing. If evidence relevant to specific groups exists, mention it here. It will also be useful to document the absence of culturally specific evidence if this is the case, and the extent to which evidence based treatments may not be appropriate for certain groups.

5. Case Vignette (0–8 ms. pages)

In some volumes, it may be appropriate to illustrate some or all of the procedures (including diagnosis) and treatment techniques by means of a case example or vignette in a separate chapter. In other volumes, it may be better to have provide shorter case examples at the appropriate points in the text (e.g., to illustrate indications for choosing particular treatments; differential diagnoses; or therapeutic procedures).

6. Further Reading (1 ms. page)

This should contain a few (1 to ca. 6) references to literature where the practitioner can find further details or background information. Each reference should be followed by a brief (2–5 lines) annotation. When choosing publications, please consider how readily available they are.

7. References (3–6 ms. pages)

The literature cited in the text, styled according to the *Publication Manual* of the American Psychological Association (APA), Sixth Edition.

8. Appendix: Tools and Resources (6–15 ms. pages)

This important part of the volume should contain material of practical use to the therapist or something that can be handed to patients (after photocopying). Possible examples include a Brief Guide to Exploration for the therapist; Symptom Diary record sheet; Form for recording the effects of treatment; Illustration of the causes/mechanism of the disorder to show the patient; Information sheet for the patient about the disorder, etc.

Length, General Style, Manuscripts, and Marginal Notes

Length. The finished, printed book should be between 80 and 100 pages long, including tables, figures, references, and appendix. This is equivalent to around 200,000–250,000 characters plus spaces, or **140–180 double-spaced manuscript pages** with 25 lines per page and 60 characters per line (12 point font), including tables, etc. Since the volumes in the series are available on a subscription basis, and the price of all volumes therefore has to be kept the same, it is essential that authors adhere to length limits.

General Style. The text and references should be prepared according to the Sixth Edition of the *Publication Manual* of the American Psychological Association (APA).

Manuscripts should be submitted by email and (upon request) as hard copy. Illustrations should be supplied both as camera-ready copy and, wherever possible, also in digital form.

Marginal Notes. The text of the marginal notes should be supplied in a separate file; the notes should be numbered and their positions in the text indicated by a handwritten number in the margin of the main manuscript. Alternatively, authors who are comfortable working with text boxes may use this feature.

Continuing Education (CE)

APA Division 12 (Society of Clinical Psychology) plans to offer home study continuing education (CE) credits based on the volumes in the series. We anticipate that reading each volume will require about 4 hours, which in turn will support 4 units of continuing education credit. APA requires a post-test of ten questions for each hour of CE credit.

Please provide 40 questions based upon your volume. These questions should be directly related to the content of the volume, and sufficiently difficult that psychologists with a general knowledge of the area should *not* be able to answer the questions correctly without having read the book. However, please avoid testing for knowledge of minutia or trivial facts. Whenever possible, link your questions with clinical practice. Present answers and distractors in alphabetical order.

The following sample questions illustrate the style and the "look and feel" of questions we intend to use in the series. Those individuals taking the posttest for continuing education credit will be required to answer at least 70% of the questions before CE credits can be awarded.

1. Borderline Personality Disorder would be classified into which of the following diagnostic clusters using criteria from the DSM-IV.
   a) Cluster A
   b) Cluster B*
   c) Cluster C
   d) Cluster D

2. Which of the following medical conditions would be LEAST important to rule out before assigning a diagnosis of somatization disorder?
   a) acute intermittent porphyia
   b) hyperparathyroidism
   c) multiple sclerosis

d) systemic lupus erythematosus
e) all of the above conditions result in vague symptoms and each can mimic somatization disorder*

3. According to the DSM-IV, the most common social phobia is:
   a) fear of eating in public
   b) fear of heights
   c) fear of public speaking*
   d) fear of using a public restroom

4. Which of the following statements is NOT supported by the research literature reviewed in this volume?
   a) In vivo exposure is more effective than exposure in imagination for treating phobias
   b) Longer exposures (e.g., 2 hours) do not lead to greater reduction in fear than shorter exposures (e.g., 30 minutes)*
   c) Treatment for specific phobias usually requires fewer sessions than treatment of panic disorder and social anxiety disorder
   d) Varying the stimulus across exposure practices improves long-term outcome

5. Dichotomous thinking, mind reading and catastrophizing are specific examples of what Aaron Beck calls:
   a) cognitive distortions*
   b) irrational beliefs
   c) schemata
   d) the cognitive triad

6. Which of the following is NOT classified as a subtype of schizophrenia using the DSM-IV criteria described in this volume?
   a) Catatonic Type
   b) Disorganized Type
   c) Paranoid Type
   d) Schizoaffective Type*

7. Which of the following changes in sleep patterns is associated with normal aging?
   a) Decreased stage 1 sleep
   b) Decreased stage 4 sleep*
   c) Decreased time to fall asleep
   d) Increased REM sleep

8. Which of the following statements concerning cognitive changes and aging is correct?
   a) About 25% of the population over the age of 65 suffers from dementia.
   b) Crystallized intelligence decreases as a person ages.
   c) Reaction time shows little change as a person ages.
   d) Short-term memory normally deteriorates as a person ages.*

9. Potential effects of exercise in the elderly include all of the following except:
   a) decreased body fat
   b) decreased depression
   c) improved hepatic functioning*
   d) Improvements in blood pressure control
   e) increased aerobic capacity

10. Your patient wishes to pursue a treatment strategy in which he can learn to control his drinking instead of stopping drinking altogether. The best available research on controlled drinking most strongly supports which of the following statements:
    a) Alcoholics who have been drinking for less than ten years are most likely to benefit from a controlled drinking approach.*
    b) If there are alcoholics who can learn controlled drinking, they cannot be identified in advance.
    c) Strategies directed toward teaching control have not shown lasting effectiveness
    d) There is no known cure for alcoholism and abstinence should be pursued.

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- **Practice-oriented:** The main emphasis is on information that the therapist or practitioner can use in his or her daily practice.
- **Easy-to-read:** The most important information is summarized in tables, illustrations, displayed boxes, and marginal notes.
- **Compact:** Each volume consists of 80–100 pages.
- **Regular publication:** We aim to publish 4 volumes each year.
- **Reasonably priced:** The list price will be around $30 per volume. Discounts will apply for members of APA Division 12 and for readers who subscribe for a minimum of 4 volumes.

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Advances in Psychotherapy – Evidence-Based Practice

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