Evaluation Findings Paper Part 2: Case of Mala

Isabella Hanley

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Dr. Melissa Murphy

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Case Summary

Identifying Information

Mala is a 25-year-old, African American female, living in Philadelphia, Pennsylvania. Prior to hospital admission on December 15, 2025, Mala was homeless. Mala is not married and has no children. Mala's biological father is deceased; Mala and her three sisters were placed in foster care. Mala was in foster care from age 4 until she aged out at the age of 21 years old. Mala has support of her aunt (Lily), two sisters (Mia and Jasmine), and Barbara (former foster mother).

Chief Complaint

When asked what the main problem she would like help with is, Mala shared she would like to go to school, get a career, and become "successful". Mala reports trying to join the military after aging out of foster care but was not accepted. Mala believes she was not accepted because of her "mental illness". Since Mala left her mother's house, she reported "walking around in the street". Mala lacks insight into her symptoms, lacks community support, and does not have stable housing. Due to the barriers stated, Mala feels she would "fail" when back into the community if there is not a long-term discharge plan.

History of Current Problem

Per CBH reviewer, Mala was voluntarily admitted to Fairmount Behavioral Health Hospital in 2017 for acute inpatient treatment. Mala was brought by her former foster mother for an intake for disorganized and erratic behavior. Mala was voluntarily inpatient for 8 days before being discharged back to her foster mother's house. In 2020, Mala voluntary was presented to Temple Episcopal Crisis Center for "trouble sleeping". After a 24-hour observation, Mala was released and received a referral for an intake of psychiatry and psychiatric evaluation at Warren E.

Smith Health Center. Mala was diagnosed with Bipolar I Disorder with Psychotic Features (F31.2) and prescribed Abilify 15 mg, once daily and Lithium 300 mg, 2x daily. Mala went to outpatient therapy at Warren E. Smith biweekly and psychiatry monthly. Mala was reportedly stable until about September of 2025 when she started to decompensate. Mala stopped taking her medication and going to outpatient appointments. Mala left her biological's mother house in November 2025 and was homeless until she presented to her Aunt Lily's house on December 2, 2025. Mala was 302'd on December 15, 2025, by her Aunt Lily and has been receiving inpatient treatment since December 18, 2025. In the 302 petition, Lily reported "*Mala has not been sleeping. There is no way she's getting more than two hours of sleep a night for the past two weeks. Her behavior is extremely disorganized. She is saying things that make no sense. She just jumps from topic to topic without stopping. She talks so fast about things that just make no sense. She told me her sister, Nia, was talking to her. Nia has been missing since 2010 and has been presumed to be deceased*."

Family Mental Health History

Mala's biological father is deceased, and her biological mother has schizophrenia and has been in and out of psychiatric facilities since Mala was a child. No information on Mala's father's mental health history is available. Mala's Mother is now stable, on a long-acting injectable, and living independently. Mala was living with her mother last year but left due to a disagreement. Mala is the youngest of four children. Mala's older sister Nia has been missing since 2010 and has been presumed to be deceased. Mala's other sisters, Mia and Jasmine, both moved out of Philadelphia and joined the military once they aged out of foster care.

Background Information

Mala's Mother lost custody of Mala in 2004 due to a DHS (Department of Human Services) case due to her mother's psychiatric illness of schizophrenia and ongoing familial condition of harmful, neglectful behavior, and lack of adequate childcare. Mala's Mother had multiple inpatient hospitalizations and was experiencing homelessness between 2004 and 2017. Barbara, Mala's former foster care mother provided treatment for foster care which was respite for Mala.

Mala has no reported substance use from childhood. Mala reports during childhood and adolescence that she struggled with her mental health. Per CBH reviewer, Mala was voluntarily admitted to Fairmount Behavioral Health Hospital in 2017 for acute inpatient treatment. Mala was brought by her former foster mother for an intake for disorganized and erratic behavior. Barbara reported that Mala was demonstrating a lack of sleep and elevated mood two weeks earlier and would leave the house at night for days at a time and wander around Philadelphia. Mala was inpatient for 8 days. Once clinically cleared, Mala was discharged back to Barbara's house and connected with outpatient therapy and psychiatry. No official diagnosis was given.

Mala aged out of foster care in 2021 and moved to North Carolina. Mala resided in North Carolina for two years and was married to an unidentified woman for 1 year. Mala reported the relationship ended due to domestic violence and alleged sexual abuse, Mala then moved back to Philadelphia in 2023 and stayed with her Aunt Lily until July of 2023 when she went to stay with biological Mother. Mala left after a disagreement in November of 2025 and was unable to be located by her family Until early December 2025 when she showed up at her aunt's house.

Mental Status Evaluation

Mala presented with extremely somatic, bizarre thought content, and preoccupied. When asked what her name was, she stated “My name is Mala it came from my father’s anus”. Mala self-reported she is diagnosed with Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Obsessive Compulsive Disorder, Borderline Personality Disorder, and schizoaffective disorder. Mala had poor eye contact during the interview, displayed a flat affect, and was internally preoccupied. Mala exhibited significant thought blocking and was impoverished. Mala exhibited paranoia towards the interviewer and asked several times, “why are you asking me questions?”. Mala endorsed auditory hallucinations of her sister Nia telling her to “roam”. She also reported visual hallucinations of shadows and reported “we play fight". When asked about symptomology, patient had minimal insight into her mental illness.

Diagnostic Summary

Based on Mala’s description, collateral from her aunt and former foster mother, Mala has experienced extensive trauma. In addition to trauma, Mala is showing concerning somatic symptoms, preoccupation, and delusions, during her current inpatient admission and prior treatment. Mala’s symptomology may be linked to childhood trauma and genetic predisposition for schizophrenia. Based on presented information, during admission assessment, Mala diagnosis of Bipolar I Disorder with Psychotic Features (F31.2) will be maintained.

Operationalization of Client Problem Targeted for Intervention

Target Problem 1: Bipolar I Disorder with Psychotic Features (F31.2)

Bipolar I Disorder with Psychotic Features (F31.2) was selected as the primary target problem because it represents Mala’s primary psychiatric diagnosis and represents the most acute

and destabilizing condition affecting her functioning. Bipolar I Disorder with Psychotic Features (F31.2) symptoms significantly impair her ability to maintain housing, relationship, treatment adherence, and education and career goal attainment.

Mala was diagnosed with Bipolar I Disorder with Psychotic Features (F31.2) by an outpatient psychiatrist from Warren E. Smith Health Center in 2020. She was prescribed Abilify 15 mg, once daily and Lithium 300 mg, 2x daily. Mala went to outpatient therapy at Warren E. Smith biweekly and psychiatry monthly. Mala was reportedly stable until about September of 2025 when she started to decompensate.

The current scope of the problem manifests through severe sleep disturbances, Per 302 petition from Mala's Aunt Lily, "*Mala has not been sleeping. There is no way she's getting more than two hours of sleep a night for the past two weeks."* She also exhibited disorganized and erratic behavior, such as jumping rapidly from topic to topic and speaking in a pressured and incoherent way. Per 302 petition from Mala's Aunt Lily, *"Her behavior is extremely disorganized. She is saying things that make no sense. She just jumps from topic to topic without stopping. She talks so fast about things that just make no sense."* Likewise, during admission assessment when asked her name, Mala stated "My name is Mala it came from my father's anus". During the interview, Mala had poor eye contact, displayed a flat affect, and was internally preoccupied. Mala exhibited significant thought blocking and was impoverished.

Bipolar I Disorder with Psychotic Features (F31.2) was selected as the primary target problem because of severe auditory and visual hallucinations. Mala endorses auditory hallucinations of her deceased sister Nia telling her to "roam". Mala reports that for the past 5 years, her sister tells her, "Where to go, what to do, and what kind of her person she should be."

Reportedly, her visual hallucinations manifest as shadow figures whom she “play fights” with. Mala could not provide additional insight about the shadow figures she sees.

Mala has minimal insight into her mental illness and a history of medication non-adherence. Mala is experiencing decompensation and functional decline that has resulted in homelessness and involuntary hospitalization. Bipolar I Disorder with Psychotic Features (F31.2) is prioritized first because Mala’s untreated psychotic symptoms and mood instability pose risks to Mala’s safety, housing stability, and ability to engage in therapeutic and medication treatment. Stabilization of psychosis and mood symptoms through medication management, psychoeducation of symptoms is necessary before the achievement of long-term goals, such as education and career aspirations. Without psychiatric stabilization of Bipolar I Disorder with Psychotic Features (F31.2) functionality in other areas of life will be hard to sustain.

Target Problem 2: Impulsivity

Symptoms of Impulsivity were selected as Mala’s second target problem because impulsive behaviors play a significant role in her psychiatric instability and disruptions to daily functioning, independent of her bipolar symptoms. Several examples from Mala’s history demonstrate patterns of maladaptive, impulsive decision making. For example, Mala reportedly stopped taking her prescribed Abilify 15 mg, once daily and Lithium 300 mg, 2x daily and stopped attending outpatient appointments at Warren E. Smith in September of 2025 without consulting with providers. When the interviewer asked Mala during intake assessment why she stopped taking medication and going to outpatient appointments, Mala stated “I don’t know, because I felt like it”. Mala was unable to provide concrete reasoning for the discontinuation of treatment. Such abrupt discontinuation of treatment led to psychiatric decompensation.

Additional examples of impulsivity include when Mala abruptly left her biological mother's house in November of 2025 following a disagreement. Per collateral with Mala's biological mother, "*we were disagreeing about cleaning up the house, I had asked Mala to help me clean up the kitchen before we went and got some food. She wanted to get food before we cleaned up. When I told her we was going to clean first, she stormed out"*. Mala remained homeless for several weeks before presenting to her Aunt Lily's house in December 2025.

Likewise, Mala's on-going safety is an issue due to impulsive decision making. Per 302 petition by Mala's Aunt Lily, Mala would leave the house at night and wander around Philadelphia alone. The frequency of the reported "roaming" reflects Mala acting on urges without consideration of personal safety. Mala abruptly moved to North Carolina after aging out of foster care and entered a brief, unstable marriage, which ended after only a year due to domestic violence and alleged sexual abuse. These behaviors demonstrate an ongoing pattern of impulsive decision making that results in disruptions to housing stability, treatment adherence, and overall life functioning.

Treating impulsivity as a second target problem following Bipolar I disorder with Psychotic Features (F31.2) is necessary to demonstrate the maladaptive patterns that have independently contributed to instability in Mala's life. Addressing impulsivity through structured interventions and behavioral monitoring will help Mala adhere to treatment, improve ability to make decisions, and maintain stability to support long term goals of stable living, career development, and education.

Literature Review

This literature review will consist of a review of two different standardized measures to assess Mala's Bipolar I disorder with Psychotic Features (F31.2) (target problem #1) and two different standardized measures to assess Mala's impulsivity (target problem #2).

Measures of Bipolar I disorder with Psychotic Features (F31.2)

The first standardized measure of the target problem #1 (Bipolar I disorder with Psychotic Features (F31.2)) is the Mood Disorder Questionnaire (MDQ). The second standardized measure of Bipolar I disorder with Psychotic Features (F31.2) is The Positive and Negative Syndrome Scale (PANSS). Both measures are reviewed next in relation to Mala's presenting circumstances.

Mood Disorder Questionnaire (MDQ)

The Mood Disorder Questionnaire (MDQ) is designed to screen for a patient's lifetime history of a manic of hypomanic symptoms associated with bipolar spectrum disorders. The Mood Disorder Questionnaire is a self-reported, single page, paper, and pencil inventory (Hirschfeld et al., 2000). The MDQ contains 13 yes or no questions about symptoms and two questions about the occurrence of manic and hypomanic symptoms during the same period and assumed functional impairment from symptoms (Hirschfeld et al., 2000).

The purpose of the MDQ is to assess validity in patients with bipolar spectrum disorders. The study by Hirschfeld et al. (2000), was designed to assess the symptom threshold when identifying bipolar spectrum disorder and the sensitivity and specificity when using a DSM-IV mental health diagnosis of bipolar spectrum disorder (Hirschfeld et al., 2000). The study was conducted at five outpatient psychiatric clinics that treated patients with mood disorders. The study included 198 patients; 124 patients were female and 74 males. All participants were 18 years of age or older and spoke English. All participants completed a Structured Clinical Interview for

DSM-IV (SCID) and received a diagnosis of bipolar spectrum disorder, including bipolar I and II. Participants then completed the MDQ (Hirschfeld et al., 2000).

The MDQ demonstrated high internal consistency, indicated by a Cronbach's alpha of .90. The MDQ items with the highest consistency were being easily distracted, irritability, and racing thoughts (Hirschfeld et al., 2000). Likewise, the results showed a total score range from .50 to .75 for the Mood Disorder Questionnaire. The internal consistency demonstrates that the MDQ was a reliable measure when screening patients with a bipolar spectrum diagnosis. The 13 symptom items were correlated with one another and accurately measure lifetime manic and hypomanic symptoms (Hirschfeld et al., 2000).

Criterion validity was assessed by comparing MDQ results to professional diagnostic interviews conducted using the Structured Clinical Interview for DSM-IV (SCID). The researchers used a screening score of 7 or more for cutoff (Hirschfeld et al., 2000). The MDQ had good sensitivity (o.73, 95% confidence interval) and good specificity (0.90, 95% confidence interval). The 7 or more-item threshold demonstrated that 7 out of 10 people with bipolar spectrum disorder would be correctly identified by the MDQ. In this specific study, 73% of patients who had bipolar disorder were correctly identified by the MDQ (Hirschfeld et al., 2000).

The MDQ would be an effective screening tool for Mala based on her symptomology. Mala experiences erratic behavior, racing thoughts, irritability etc. The MDQ would assess her lifetime history of manic symptoms and her diagnosis of Bipolar I with Psychotic Features (F31.2).

Limitations of Mood Disorder Questionnaire (MDQ). A weakness of this study was the lack of cultural and demographic inclusions. The sample was 90% Caucasian and English speaking. The generalizability of other cultural groups is uncertain.

The Positive and Negative Syndrome Scale (PANSS)

The Positive and Negative Syndrome Scale (PANSS) was developed to assess symptoms associated with schizophrenia and bipolar disorders. Developed by Andreasen and Olsen in 1982, PANSS is a likert-type scale that consists of 30-items, a sixteen-point severity scale that follows the format of the Brief Psychiatric Rating Scale, seven-item scale for the assessment of positive symptoms (SAPS) and seven-item scale for the assessment of negative symptoms (SANS) (Kay et al., 1987, p. 100).

Positive symptom domains include hallucinations, delusions, and conceptual disorganization, grandiosity, etc. (Kay et al., 1987, p. 101). Negative symptom domains include blunted affect, emotional withdrawal, and lack of motivation, and poor rapport (Kay et al., 1987, p. 102). Each domain is rated on a 7-point scale, ranging from 1 "absent" to 7 "extreme"; total scores range from 30 to 210 (Kay et al., 1987, p. 109). In the current study, the PANSS interview was completed during a structured clinical interview and took between 30-45 minutes to complete (Kay et al., 1987, p. 101).

Kay et al. (1987) conducted a validity study with 82 patients in an inpatient setting who met DSM-III criteria for schizophrenia. The sample included two groups, an "acute schizophrenia" group of 31 patients and a "chronic schizophrenia" group of 51 patients (Kay et al., 1987, p. 101). The sample was used to evaluate reliability and criterion-related validity of the scale.

PANSS demonstrated strong interrater reliability, with a strong level of consistency among raters. Agreement among clinicians ranging from .83 to .87 across the PANSS scales (Kay et al., 1987, p. 102). This is important because it shows that scales are reliable across different raters. The study also demonstrated high PANSS criterion-related validity. There was a strong correlation

between the PANSS positive and negative scales and corresponding symptom ratings from the Scale for the Assessment of Positive Symptoms and Scale of Assessment of Negative systems (r = .77 for both). PANSS scores reflect what other symptom scales measure. For example, the PANSS positive symptom scale correlates with the Scale for the Assessment of Positive Symptoms. Patients with acute and chronic schizophrenia had highly related scores (Kay et al., 1987, p. 103). The PANSS study showed evidence of internal reliability (a coefficients = 0.73, 0.83, and 0.79 for the positive, negative, and GPS 105 scales, respectively). This shows that the item in each scale measures the same construct and has a Cronbach's alpha that is considered acceptable and internally consistent. The study also showed high test-retest reliability when conducted over a 3-to-6-month inpatient phase (r = 0.80,0.68, and 0.60) (Kay et al., 1987, p. 104). This is important because it demonstrates that if the PANSS is given to patients at different times, scores will remain stable.

PANSS is also effective when working with clients presenting with hallucinations, delusions, social withdrawal, and flat affects. It identifies which symptoms are most severe, distinguish positive versus negative symptom patterns, and monitor changes during treatment. PANSS would be useful for assessment of Mala to evaluate treatment effectiveness, especially medication use. PANSS provides standardized symptom measurement that could be tailored to the treatment of her specialized symptoms.

Limitations of the PANSS. Kay et al. (1987) discussed that despite reliability and validity, additional research on the interrater concordance of the PANSS is needed (Kay et al., 1987, p. 101).

Measures of Impulsivity

The first standardized measure of impulsivity or target problem #2 is the S-UPPS-P Impulsivity Scale. The second standardized measure of target problem #2 is Barrat Impulsivity scale (BIS-11). Both measures are reviewed next in relation to Mala's presenting circumstances.

S-UPPS-P Impulsivity Scale

The S-UPPS-P Impulsive Behavior Scale is used to measure impulsivity dimensions by assessing personality traits. The scale assesses five dimensions of impulsive behavior as follows, negative urgency, which represents acting impulsively when experiencing negative emotions, positive urgency, or acting impulsively during intense positive emotions, lack of premeditation, acting without thinking about consequences, lack of perseverance, difficulty maintaining focus on difficult or boring tasks, and sensation seeking, desire for exciting or risky experiences (Samiefard et al., 2022, p. 174). The dimensions represent distinct ways in which impulsivity can lead to risky and problematic behaviors.

The S-UPPS-P is a 20 item, self-reported questionnaire that uses a 4-point likert scale, ranging from "strongly agree" to "strongly disagree" to measure the four impulsivity dimensions (Samiefard et al., 2022, p. 176). Samiefard et al (2022) conducted a validity and reliability study. The study analyzed the first translation of the revised short form of the UPPS-P scale (S-UPPS-P) on a Persian-speaking sample. The study examined the relationship between impulsivity and working memory. Participants completed the S-UPPS-P and the Positive and Negative Affect Scale (PANAS), the Buss and Perry Aggression Questionnaire, the Behavioral Inhibition and Activation Scales (BIS/BAS), and the Wechsler Digit Span Task (WDST) (Samiefard et al., 2022, p. 174). Although the article does not explicitly report the exact administration time, the S-UPPS-P is described as a short, self-report questionnaire, indicating it is designed to be quick The original

UPPS-P contains 59 items, the short form was created to make the assessment less time consuming in clinical settings (Samiefard et al., 2022, p. 175).

The scale is intended to be used with participants who exhibit high levels of impulsivity. Impulsivity is associated with a need for reward and activation of the behavioral activation system. The S-UPPS-P is useful with those who exhibit on going risk-taking behavior a those who are not responsive to signs of punishment (Samiefard et al., 2022, p. 174).

Overall, the study showed that the S-UPPS-P has a strong structure like that of the UPPS original scale, strong construct validity, and good test-retest reliability (Samiefard et al., 2022, p. 174). In this study, Cronbach's alpha coefficients ranged from .71 to .83 across the five impulsivity dimensions. The alpha represents adequate internal consistency (Samiefard et al., 2022, p. 179). Cronbach's alpha scores suggest that the four items within each subscale, negative urgency, positive urgency, lack of premeditation, lack of perseverance, and sensation seeking, reliability measure each necessary impulsivity traits.

The researchers conducted Confirmatory Factor Analysis (CFA) to test multiple models of the scale structure. Four competing models were evaluated including, a single factor model to represent impulsivity as one general trait, a five-factor model to represent impulsivity dimensions separately, a three-factor model to combine some impulsivity traits, and a hierarchical model with higher order impulsivity factors (Samiefard et al., 2022, p. 177). Based on the study discussion, the best fitting models were two five-factor models, where dimensions were interrelated with other dimensions of impulsivity (Samiefard et al., 2022, p. 182). The findings demonstrate that impulsivity is a multifaceted personality trait of different components. For example, a lack of premeditation and lack of perseverance combine for many participants to form a lack of conscientiousness factor.

The S-UPPS-P would be a good fit for Mala because it would measure different aspects of her impulsivity. Behavior such as wandering the streets for days, leaving home suddenly, and stopping medication, suggest challenges with impulse control. The S-UPPS-P would help clinicians better understand the specific type of impulse that influences her behavior.

Limitation of S-UPPS-P. A limitation of this study could be viewed as reduced reliability due to the study using a short version. The short version is intended to improve efficiency. In this study, Cronbach's alpha values in this study were acceptable (.71-.83) but when using a short version, there is the possibility of a reduction in reliability compared to longer measures.

Barrat Impulsiveness scale (BIS-11)

The Barratt Impulsiveness Scale (BIS-11) is designed to measure impulsivity and has been used in impulsivity related research for over 50 years (Reise et al., 2013, p. 2). The scale assesses the following three subdomains of impulsivity; attention, motor, and non-planning. The BIS-11 contains 30 items; the items are self-rated on a scale of 1 to 4. Responses are given on a four-point scale, ranging from "rarely/never" to "almost always" (Reise et al., 2013, p. 4). The article does not report on a specific administration time. In this specific study, the scale was self-administered on the computer, and responses were automatically recorded (Reise et al., 2013, p. 4).

Reise et al. (2013) administered the BIS-11 to a community sample of 691 adults, ranging in age from 21 to 51 years old. Participants were recruited from the local community through flyers, internet postings, and community presentations by researchers (Reise et al., 2013, p. 4). The study reported internal consistent reliability for the BIS-11 total score. Cronbach's coefficient alpha was .80 for total scores. The score indicated acceptable internal consistency, suggesting that overall, the items of the scale show a moderate level of consistency when measuring impulsivity

generally (Reise et al., 2013, p. 6). Unfortunately, the average item inter-correlation was only .13, which indicated low variance (Reise et al., 2013, p. 6).

The goal of the study was to test four theories of the BIS-11 structure through four models. The models included a unidimensional model, a six correlated first-order factor model, a three second-order factor model, and a bifactor model (Reise et al., 2013, p. 9). Based on the results of the Bifactor Model, there were issues with the factor structure of the scale. Some items had very low correlation with other items. Likewise, several items had cross loadings across multiple factors, showing there was association between more than one impulsivity dimension. The confirmatory factor analysis showed many of the factors were over redundant or did not fit the factors (Reise et al., 2013, p. 9) Results from the bifactor model showed that 61% of the score variation was explained by this general impulsivity but not the other dimensions (Reise et al., 2013, p. 7).

Since the BIS-11 assesses impulsive tendencies through self-reported behavior and thinking patterns, it could be useful with Mala to help quantify the extent to which impulsive tendencies are contributing to her level of functioning. For example, the scale looks at attentional impulsivity; Mala shows thought blocking, rapid topic shifts, and disorganized speech.

Limitations of the Barrat Impulsiveness scale (BIS-11). Cross loading of items across factors reduces the distinctiveness of the factors and makes it hard to interpret the subscales as representing separate entities of impulsivity.

Identification of Validated Measures

Target Problem #1 (Bipolar I Disorder with Psychotic Features (F31.2)): The Positive and Negative Syndrome Scale (PANSS)

The most appropriate scale to measure Mala's Bipolar I Disorder with Psychotic Features (F31.2) would be The Positive and Negative Syndrome Scale (PANSS). This scale is included in appendix A. PANSS would be the most appropriate measure because it directly assesses psychotic symptom severity, which represents a major part of Mala's clinical presentation. The multidimensional aspect of this scale evaluates delusions, hallucinations, disorganization, and blunted affect (Kay et al., 1987, p. 101). Likewise, Mala already has a diagnosis of Bipolar I Disorder with Psychotic Features (F31.2) and is experiencing current psychotic symptoms, PANSS provides a more comprehensive assessment of ongoing severity, rather than serving as just a screening tool like the other measure. In addition, PANSS would be an appropriate scale because it is administered by a clinician during a structured interview. Mala has limited insight into her mental illness and symptoms, which could pose as a barrier to completing self-reported measures, like the other measure. Compared to other scales reviewed, the PANSS has strong reliability and validity, with good interrater reliability (.83-.87) and good internal consistency (alphas .73 - .83) (Kay et al., 1987, p. 103). There was a strong correlation between the PANSS positive and negative scales and corresponding symptom ratings from the Scale for the Assessment of Positive Symptoms and Scale of Assessment of Negative systems (r = .77 for both). PANSS is a useful scale for patients experiencing both positive and negative symptoms associated with Bipolar I Disorder with Psychotic Features (F31.2) (Kay et al., 1987, p. 102). PANSS is the best scale to measure Mala's psychotic symptoms related Bipolar I Disorder with Psychotic Features (F31.2) as the scale assesses which symptoms are most severe, distinguish positive versus negative symptom patterns, and monitor changes during treatment.

Target Problem #2 (Impulsivity): The S-UPPS-P Impulsive Behavior Scale

The most appropriate scale to measure Mala's target problem #2 would be the S-UPPS-P Impulsive Behavior Scale. This scale is more favorable because it would allow a clinician to measure the complexity of Mala's impulsivity and see what type of impulsivity is responsible for different behaviors. The other measure tracks impulsivity as a single trait. The S-UPPS-P measures multiple dimensions of impulsivity, including negative urgency, positive urgency, lack of premeditation, lack of perseverance, and sensation seeking (Samiefard et al., 2022, p. 174). The S-UPPS-P also had good reliability compared to the other measure. The S-UPPS-P had a Cronbach's alpha value of .71-.83, which demonstrates good internal consistency and reliability (Samiefard et al., 2022, p. 179). Whereas the other scale had structure problems demonstrated in the confirmatory factor analysis. The confirmatory factor analysis showed many of the factors were over redundant or did not fit the factors (Reise et al., 2013, p. 9). In addition, the S-UPPS-P is efficient for use in clinical settings. The S-UPPS-P is the revised short form of the UPPS-P scale. The S-UPPS-P is 20 items and described as a short, self-report questionnaire, compared to the original UPPS-P which contains 59 items. The short form was created to make the assessment less time consuming in clinical settings (Samiefard et al., 2022, p. 175). The S-UPPS-P would be beneficial for a clinician working with Mala in an inpatient setting to decrease the risk of burden and further psychological distress.

Self-Created Measure for Bipolar I Disorder with Psychotic Features (F31.2)

Psychotic symptoms associated with Mala's diagnosis of Bipolar I with Psychotic Features (F31.2) were selected as the primary target problem because it represents Mala's primary psychiatric diagnosis and accounts for decompensating symptoms affecting her functioning. During intake assessment and collateral from 302 petition, Mala reported acute symptoms of mania and psychosis. Mala demonstrated disorganized thinking, pressured speech, and auditory and

visual hallucinations. Bipolar I Disorder with Psychotic Features (F31.2) symptoms significantly impair her ability to maintain housing, relationship, treatment adherence, and education and career goal attainment. In addition to The Positive and Negative Syndrome Scale (PANSS), the self-created measure for Mala's first target problem is a "Hallucination Log" and is included in Appendix C. The log would be completed daily and consists of 7 open ended questions to record the intensity, frequency, emotional experience, and behavioral experience of hallucinations. The goal is to track hallucinations shortly after they occur and give insight into the specificities of Mala's psychotic symptom experiences and treatment progress. The log represents a qualitative approach to measure Mala's first target problem.

Operationalized Intervention(s)

Intervention

The intervention chosen to work with Mala is a psychoeducational and manualized approach called Cognitive Behavior Therapy for Psychosis (CBTp).

Definition and Purpose of CBTp

Cognitive Behavior Therapy for Psychosis (CBTp) was selected to address both target problems, Bipolar I Disorder with Psychotic Features (F31.2) and impulsivity. CBTp was selected because it is a modifiable, structured, and goal-based based treatment intervention. CBTp is an adaptation of traditional CBT designed specifically for individuals experiencing psychosis (Landa, 2017). CBTp is a frontline treatment that was developed in 1952 for patients with psychotic related disorders. CBTp is beneficial for patients with persistent psychotic symptoms and whom are often not adherent to medication regiments and other psychoeducational interventions (Avasthi, Sahoo, and Grover, 2020). The goal of CBTp is to improve insight into

psychotic and impulsive experiences and to develop coping to decrease associated distress and functional impairment (Avasthi, Sahoo, and Grover, 2020).

Overall, CBTp emphasizes a collaborative therapeutic alliance, a normalizing approach to negative experiences, exploration of beliefs and experiences through collaborative empiricism, and development of alternative explanations of experiences to reduce distress. In patients with psychotic features and impulsivity, CBTp is beneficial to reduce distress and severity of hallucinations and disorganized thinking, improve insight into mental illness, modify maladaptive beliefs driving behavior, and reduce impulsive and unsafe decision making (Landa, 2017). CBTp is a treatment approach that creates a comprehensive psychological framework that focuses on helping patients make sense of their symptoms and improve functioning (Landa, 2017).

Components of CBTp

The first step of CBTp is engagement and normalization. This stage includes clinician and patient rapport building and development of a strong and viable relationship. The initial relationship building is important to decrease paranoia and mistrust from the patient (Avasthi, Sahoo, and Grover, 2020). Clinicians should use a non-confrontational "Columbo style" approach. A "Columbo style" approach is based on motivational interviewing and is open and non-judgmental (Landa, 2017). Appropriate approaches to increase engagement include resolving ambivalence and normalizing experiences. For example, normalizing experiences of the patient include reducing stigma about experiences and that despite distressing experiences, the patient is not that different from others.

The second step of CBTp is the assessment phase. Assessment is necessary to create a formulated treatment plan. Assessment in CBTp includes assessing psychotic experiences,

assessment of early experiences, core beliefs, biases, distortions, safety behaviors, impulsivity, and triggers (Landa, 2017). Assessment phases also evaluate triggers that can lead to impulsive behaviors, such as sleep deprivation or interpersonal conflict. General assessments include a detailed history and mental state examination that includes assessing the impact of symptoms on functioning, coping strategies, and assessment of current routine and daily activities (Avasthi, Sahoo, and Grover, 2020). Two assessment approaches in CBTp include the ABC Model and the Narrative Approach (Landa, 2017). When using the ABC Model, the activating event, belief, and consequences are identified in comparison to the current symptoms. When assessing psychosis, the ABC Model can be useful to identify the duration, impact, associated distress, quality, and intensity of hallucinations and delusions (Landa, 2017).

Phase three of CBTp is formulation and psychoeducation. Psychoeducation strategies educating the patient on the nature and course of symptoms (Avasthi, Sahoo, and Grover, 2020). Formulation processes involve creating an exploratory model for the development of patient symptoms. The goal is to validate the patient's existing thought processes of their experiences by walking through how they came to conclusion they did, and to explore alternative explanations of experiences that may be more conclusive and less distressing (Landa, 2017). Formulation helps to understand the relationship between problems, chose specific treatment modalities, predict behaviors, and understand where non-compliances arise (Landa, 2017).

The next stage is CBT and behavioral skill training intervention. This phase targets maladaptive beliefs that increase both psychosis and impulsivity. CBT components involve analyzing the cognitive processes of the patient (Avasthi, Sahoo, and Grover, 2020). An example of a case formulation during this stage includes working with a patient to identify and reduce triggers that would lead to impulsive behavior or delusions. This can be accomplished by

completing reality testing and completing behavioral experiments (Landa, 2017). CBTp behavioral skills training, such as reality-based activities, should be tailored to the patient's specific symptoms and based on the scope of the presenting concerns and target problem improve a patient's ability to cope with psychotic symptoms and impulsivity (Avasthi, Sahoo, and Grover, 2020).

The last phase of CBTp is relapse prevention strategies. This phase includes routine maintenance and recognition of decompensation warning signs and development of safety plans in the event of relapse (Avasthi, Sahoo, and Grover, 2020). Relapse work is necessary to ensure that the patient has a necessary level of confidence in the ability to use skills to ensure that they manage symptoms independently. Relapse prevention by a clinician includes analyzing and assessing symptoms, occurrences, and triggers related to previous decompensation (Landa, 2017).

Overall, CBTp aims to help individuals develop a comprehensive understanding of their experiences related to psychosis and impulsivity. CBTp is effective for patients whose symptoms reflect decreased functionality, disorganization, and limited insight (Landa, 2017). Likewise, previous research has demonstrated the effectiveness of CBTp in reducing positive symptoms when administered in combination with pharmacological treatment (Kumar et al., 2020).

Anticipated Effects of Interventions on Client Target Problems

Effect on Target Problem 1: (F31.2) Bipolar I Disorder with Psychotic Features (PANSS)

Cognitive Behavioral Therapy for Psychosis (CBTp) is expected to improve Mala's (F31.2) Bipolar I Disorder with Psychotic Features by targeting her decreased functionality, disorganization, emotional distress, and maladaptive coping responses that maintain exacerbate her psychotic symptoms. CBTp will reduce the frequency of functional impact related to hallucinations and delusions. CBTp helps Mala develop coping strategies that decrease the

intensity of hallucinations, such as hearing her sister's voice, instead of targeting just symptom elimination. Prior research from Health Quality Ontario (2018) demonstrates that CBTp interventions improve psychotic symptoms, including positive and negative symptoms (Health Quality Ontario, 2018). Likewise, Zimmerman et al. (2005) found that patients within acute psychosis that partook in CBTp treatment had a significant reduction in positive symptoms with a mean effect size of 0.37 compared to adjunctive measures (Zimmermann et al., 2005). This is especially relevant for Mala, to target coping skills needed to decrease symptoms such as roaming and disorganized speech.

Second, CBTp will increase Mala's ability to identify and address her psychotic experiences. Mala will learn to identify hallucinations, delusions, and disorganized thought processes and compare them with real life experiences. CBTp works to improve a patient's ability to evaluate their thoughts against reality and increases the ability to correctly use reality testing and cognitive flexibility (Health Quality Ontario, 2018).

Third, CBTp is expected to improve Mala's insight into her illness. During her clinical presentation, Mala had limited insight into her symptoms and experiences. CBTp will help Mala make connections between events, such as the traumatic effects of her sister going missing, to her symptoms. Improved insight is necessary to form long-term treatment engagement and medication compliance. CBTp is recommended in combination with pharmacotherapy to improve symptom recognition and overall functioning (Health Quality Ontario, 2018).

Overall, CBTp is expected to reduce the severity, frequency, and behavioral impact of Mala's psychotic symptoms related to her diagnosis of (F31.2) Bipolar I Disorder with Psychotic

Features while improving her insight and engagement in treatment. CBTp is an effective intervention for reducing positive and negative symptoms (Kumar et al., 2020).

Effects on Target Problem 2: Impulsivity (S-UPPS-P)

CBTp will reduce Mala's impulsivity by helping to increase Mala's awareness of triggers related to her impulsive behavior. Through structured functional analysis and symptom monitoring Mala and a clinician will be able to conjunctively identify patterns that precede maladaptive behavior, such as the frequency of impulsive actions occurring during periods of lack of sleep or when she is experiencing an increased mood. CBTp structured self-monitoring tools, like a mood or sleep log, will help Mala identify warning signs that proceed impulsive behaviors (Landa, 2017).

Second, CBTp will strengthen cognitive controls related to impulsivity. For Mala, impulsive behaviors are linked to an inability to pause and think rationally before acting. CBTp will target this by helping her adjust cognitions related to automatic thought behavior patterns, such as with cognitive restructuring (Avasthi et al., 2020). For example, when Mala experiences thoughts related to leaving her environment, she will be prompted to evaluate associated consequences before acting. CBTp will help Mala improve practicial skills, such as "pause and review," to delay impulsive responses. For Mala, this is necessary when she experiences urges to leave treatment settings and discontinue medication (Health Quality Ontario, 2018).

Evaluation Design Tracking

Overview of Administration

To monitor Mala's progress and evaluate the effectiveness of treatment, a single-subject A–B–A design will be used. During the initial session, her baseline will be established by

collecting initial scores on the PANSS (Appendix A) and the S-UPPS-P (Appendix B) before CBTp is introduced. The intervention phase ("B") will then be implemented, during which both measures will be administered consistently from sessions 2 through 10 to track changes over time.

Following the intervention phase, two follow-up sessions will be conducted in which the PANSS and S-UPPS-P will be re-administered after CBTp is withdrawn to determine whether treatment gains are maintained or decrease once the intervention is no longer being provided. The self-created daily Hallucination Log (Appendix C) will be used to qualitatively track her experiences related to Bipolar I Disorder with Psychotic Features (F31.2). This log will be used in addition to the quantitative data collected with PANSS to assess individualized information related to the frequency, intensity, and content of hallucinations, offering a more comprehensive understanding of changes in her primary target problem.

Data Collection in Session

Data will be collected within the inpatient psychiatric unit during scheduled, weekly, structured clinical sessions with additional ongoing monitoring across sessions. The clinician will administer the PANSS (Appendix A) to assess symptoms associated with Bipolar I Disorder with Psychotic Features (F31.2) and the S-UPPS-P Impulsivity Scale (Appendix B) to measure levels and dimensions of impulsivity. The average total time to complete both measures will be approximately 20–30 minutes. These measures will be completed on a weekly basis to track symptom change at baseline, during the CBTp intervention phase, and follow-up.

Scores from the PANSS will be recorded weekly and graphed to monitor changes in positive symptoms, negative symptoms, and general psychopathology. PANSS will help to

monitor reductions in hallucination frequency, disorganization, and functionality as indicators of treatment effectiveness.

Scores from the S-UPPS-P will also be recorded weekly and graphed to track changes in impulsivity across negative urgency, positive urgency, lack of premeditation, lack of perseverance, and sensation seeking subscales. Higher scores on S-UPPS-P will indicate greater impulsivity, while lower scores will indicate increased impulsivity. A reduction in impulsive decisions, such as medication nonadherence, wandering, and behavioral changes, will be relevant evidence of treatment progress.

In addition to the two identified standardized measures, Mala will complete a daily Hallucination Log (Appendix C) to track auditory and visual hallucinations. The log will be completed daily as events occur or as soon as clinically appropriate afterward. This qualitative data will be used alongside PANSS scores to provide a more detailed and individualized understanding of symptom changes over time.

Finally, behavioral observations will be documented during each CBTp session. Behavioral observations will include level of engagement, organization or thoughts, and openness to intervention strategies. The overall goal of treatment is for PANSS scores to decrease over time and for S-UPPS-P scores to decrease. These changes, along with improvements in Mala's daily functioning, will indicate positive treatment response to CBTp.

Presentation and Interpretation of Case Data

`Data using the Positive and Negative Syndrome Scale (PANSS) and the Short UPPS-P Impulsive Behavior Scale (S-UPPS-P) was collected throughout the 13 weeks intervention period,

with Cognitive Behavioral Therapy for Psychosis (CBTp) implemented as the treatment intervention from weeks 2 to 10. The PANSS and S-UPPS-P were administered on a weekly basis, including during week 1 for baseline and weeks 12 and 13 to assess scores after the intervention period. The results of the PANSS and S-UPPS-P scores were graphed to show changes in psychotic symptom related to Mala's diagnosis of Bipolar I Disorder with Psychotic Features (F31.2) and impulsivity. For PANSS, the scores from subscales will be added together each week; a score of <50 indicates mild psychotic symptoms, while a score of >95 indicated severe illness. Similarly, each week the scores from the 5 S-UPPS-P subscales will be added together, lower scores (<34) indicate low levels of impulsivity, while higher scores (>65) indicate high impulsivity. In addition to the PANSS and S-UPPS-P, a daily Hallucination Log was used to collect qualitative data regarding the frequency, intensity, and behavioral response of hallucinations. In combination, these measures provide a combined view of Mala's functioning across treatment and assessment domains.

Overall, based on the interpretation of the case data, it can be expected that improvements in both target problems would be observed over time. A reduction in PANSS indicates decreased severity of hallucinations, disorganized thinking, paranoia, and functional impairment. During baseline, Mala scored 92, indicating severe psychotic symptoms. Similarly, a reduction in S-UPPS-P scores would suggest improvements in impulsivity, such as through the reduction of negative urgency and challenges with behavioral inhibition. During baseline, Mala scored an 83 showing high levels of impulsivity. As previously stated with CBTp intervention, she was intended to experience noticeable changes in coping skills, impulsivity, and treatment adherence. Following the introduction of CBTp there was a gradual decline in both scores. By the end of the intervention phase at week 10, PANSS score decreased to 32 and S-UPPS-P score was 22. Both scores remained

decreased at follow-up compared to baseline demonstrating symptom maintenance. CBTp is a structured intervention that works to decrease distressing symptoms, while teaching coping skills, cognitive reframing, and self-regulation (Landa, 2017). The findings suggest that the implementation of CBTp is effective in reducing both psychotic symptoms and impulsivity.

While the data may suggest a causal relationship, alternative explanations may be considered. Specifically, that treatment was provided while in a structured, inpatient, behavioral health setting. Within this setting, there is consistent medication adherence enforced, reduced environmental stressors, and 24/7 monitoring, all of which could contribute to symptom improvement independent of the intervention. Similarly, the use of self and therapeutic alliance could potentially influence treatment engagement. Establishing a strong therapeutic alliance is a core principle and one of the most important steps in CBTp (Avasthi, Sahoo, and Grover, 2020). In addition, a slight increase in symptoms and scores was noticed during the withdrawal phase. This indicates that symptom reduction was not fully maintained without CBTp. Prior research indicates that continued intervention and therapeutic engagement is important for maintaining decreased occurrence of symptoms (Zimmermann et al., 2005).

Critique of Evaluation Process

Strengths

The evaluation process demonstrates several strengths, particularly the use of standardized assessment tools. The use of standardized, validated assessment measures strengthens the reliability of the current findings. For example, The PANSS is structured, clinician-administered measure of psychotic symptoms, which is especially appropriate based on Mala's limited insight and active, acute symptoms. PANSS has strong interrater reliability and assesses multiple, in-depth

domains of psychotic symptoms (Kay et al., 1988). Likewise, S-UPPS-P has a strong structure like the original UPPS original scale, with strong construct validity, and good test-retest reliability, which is important when assessing multiple dimensions of impulsivity and behavioral changes based on different symptom domains (Samiefard et al., 2022, p. 174).

In addition, the inclusion of a daily Hallucination Log represents a strength in the evaluation process. The hallucination log collected necessary qualitative data that views Mala's lived experience. This tool allows for ongoing records of the frequency, intensity, and emotional impact of hallucinations in real time to capture individualized insight that the standardized measures do not account for. Mala's personal experiences with hallucinations recorded through the daily log are consistent with a client-centered approach.

The use of CBTp is a strength generated to motivate the client. CBTp emphasizes a collaborative approach between Mala and the clinician to understand symptoms. CBTp is based on collaborative empiricism and focuses on a shared understanding of Malas behaviors, thoughts, and experiences. A positive therapeutic alliance through CBTp enhances treatment engagement and motivation (Landa, 2017). Mala is more likely to be engaged in treatment ongoing if she can recognize how engagement results in symptom improvements.

Limitations

The greatest limitation of this evaluation is the use of self-reported data collected from the S-UPPS-P and Daily Hallucination Log. Mala demonstrates limited insight into her symptomology, and struggles to recognize the connection between her thoughts, behavior, and emotions. Her inability to accurately engage with and report her experiences with hallucinations and impulsivity may impact the reliability and validity of data. The use of clinically administered tools, such as

PANSS, helps to mitigate this limitation, but potential discrepancies between clinically collected and self-reported data might impact the overall treatment outcomes.

Broader Implications for Social Work

This case has important implications for social work practice, specifically in the treatment of individuals with severe and persistent mental illness. The integration of CBTp with standardized assessment tools highlights the importance of combining evidence-based clinical interventions with structured measures. Based on the results of this evaluation process, I would recommend this approach to other social workers working with patients that have complex presentations, specifically in an inpatient, acute, behavioral health setting. Mala's history of foster care placement, family mental illness, homelessness, and trauma demonstrates the need for an intervention that is holistic and trauma informed to decrease acute symptoms while also addressing broader social determinants of health. Likewise, the intervention would be effective for patients experiencing impulsivity, hallucinations, delusions, and functional impairment. CBTp is effective to help patients improve skills for symptom management, reduce distress, and enhance coping (Avasthi, Sahoo, and Grover, 2020).

Level of Effort

The level of effort required for this evaluation process is moderate. The intervention involves weekly administration of the PANSS and S-UPPS-P with subsequent daily completion of the Hallucination Log. Administration requires monitoring and documentation from both the clinician and client. In addition, CBTp as an intervention follows a multi-phase structured course requiring engagement, assessment, formulation, goal, intervention, and relapse prevention processes (Landa, 2017). Although CBTp can be tailored to meet the client where they are at,

sessions include reviewing homework assignments, complementing mood checks, assessing progress, skill work, etc., all of which require a high level of engagement during the treatment period (Landa, 2017).

Effectiveness

CBTp is expected to be effective in addressing psychotic symptoms and impulsivity when implemented in combination with medication management. Prior research suggests that CBTp interventions are useful for patients experiencing psychosis and related symptoms when administered in adjunct to pharmacological therapy to improve symptoms, self-esteem, medication adherence, and insight about mental illness (Avasthi, Sahoo, and Grover, 2020). Likewise, CBTp improves how patients understand and relate to their symptoms, which leads to better functional outcomes even when symptoms are not fully resolved (Avasthi et al., 2020). In addition, the collaborative nature of CBTp is effective in increasing engagement in treatment. CBTp focuses on empathy, normalizing, a skill building necessary to help patients increase insight into their individualized symptoms and associated course of treatment. Improved insight is associated with better treatment adherence and long-term outcomes (Health Quality Ontario, 2018).

Feasibility and Efficiency

The intervention and evaluation plan are feasible within an inpatient psychiatric setting. The PANSS and S-UPPS-P are efficient measures based on brief administration time and clinical availability (Kay et al., 1988). The Hallucination Log also adds value while creating minimal burden for clinicians and patients. Likewise, CBTp is structured, adaptable, and goal oriented making it logical for supporting patients with severe mental illness.

Citations

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Appendix A

PANSS RATING FORM

		absent	minimal	mild	moderate	moderate severe	severe	extreme
P1	Delusions	1	2	3	4	5	6	7
P2	Conceptual disorganisation	1	2	3	4	5	6	7
P3	Hallucinatory behaviour	1	2	3	4	5	6	7
P4	Excitement	1	2	3	4	5	6	7
P5	Grandiosity	1	2	3	4	5	6	7
P6	Suspiciousness/persecution	1	2	3	4	5	6	7
P7	Hostility	1	2	3	4	5	6	7
N1	Blunted affect	1	2	3	4	5	6	7
N2	Emotional withdrawal	1	2	3	4	5	6	7
N3	Poor rapport	1	2	3	4	5	6	7
N4	Passive/apathetic social withdrawal	1	2	3	4	5	6	7
N5	Difficulty in abstract thinking	1	2	3	4	5	6	7
N6	Lack of spontaneity & flow of conversation	1	2	3	4	5	6	7
N7	Stereotyped thinking	1	2	3	4	5	6	7
G1	Somatic concern	1	2	3	4	5	6	7
G2	Anxiety	1	2	3	4	5	6	7
G3	Guilt feelings	1	2	3	4	5	6	7
G4	Tension	1	2	3	4	5	6	7
G5	Mannerisms & posturing	1	2	3	4	5	6	7
G6	Depression	1	2	3	4	5	6	7
G7	Motor retardation	1	2	3	4	5	6	7
G8	Uncooperativeness	1	2	3	4	5	6	7
G9	Unusual thought content	1	2	3	4	5	6	7
G10	Disorientation	1	2	3	4	5	6	7
G11	Poor attention	1	2	3	4	5	6	7
G12	Lack of judgement & insight	1	2	3	4	5	6	7
G13	Disturbance of volition	1	2	3	4	5	6	7
G14	Poor impulse control	1	2	3	4	5	6	7
G15	Preoccupation	1	2	3	4	5	6	7
G16	Active social avoidance	1	2	3	4	5	6	7

From https://www.studypool.com/documents/4896016/panss-scale

Appendix B

Negative Urgency (M = 1.35, SD = 0.70; Range: 0.00 – 3.00; α = 0.78)	
6. (14.)	When I feel bad, I will often do things I later regret in order to make myself feel better now.
8. (18.)	Sometimes when I feel bad, I can't seem to stop what I am doing even though it is making me feel worse.
13. (24.)	When I am upset I often act without thinking.
15. (28.)	When I feel rejected, I will often say things that I later regret.
Lack of Perseverance (M = 0.64, SD = 0.54; Range: 0.00 – 2.67; α = 0.79)	
1. (4.)	I generally like to see things through to the end. (R)
4. (12.)	Unfinished tasks really bother me. (R)
7. (16.)	Once I get going on something I hate to stop. (R)
11. (22.)	I finish what I start.
Lack of Premeditation (M = 0.80, SD = 0.56; Range: 0.00 – 2.50; α = 0.85)	
2. (5.)	My thinking is usually careful and purposeful.
5. (13.)	I like to stop and think things over before I do them. (R)
12. (23.)	I tend to value and follow a rational, "sensible" approach to things. (R)
19. (39.)	I usually think carefully before doing anything. (R)
Sensation Seeking (M = 1.78, SD = 0.73; Range: 0.00 – 3.00; α = 0.74)	
9. (19.)	I quite enjoy taking risks.
14. (25.)	I welcome new and exciting experiences and sensations, even if they are a little frightening and unconventional.
16. (29.)	I would like to learn to fly an airplane.
18. (37.)	I would enjoy the sensation of skiing very fast down a high mountain slope.
Positive Urgency (M = 0.90, SD = 0.74; Range: 0.00 – 3.00; α = 0.85)	
3. (10.)	When I am in great mood, I tend to get into situations that could cause me problems.
10. (20.)	I tend to lose control when I am in a great mood.
17. (35.)	Others are shocked or worried about the things I do when I am feeling very excited.
20. (52.)	I tend to act without thinking when I am really excited.

Note. Item numbers indicate the item order on the Short UPPS-P, whereas numbers in parentheses indicate the original item numbers on the UPPS-P. All items are rated on a four point scale from 1 (strongly agree) to 4 (strongly disagree). Items with an (R) are reverse coded, so that higher values indicate more impulsive behavior. Total subscale or Mean subscale scores can be calculated.

From https://www.semanticscholar.org/paper/Examination-of-a-Short-Version-of-the-UPPS-P-Scale-Cyders-Littlefield/1bbbb1bda8977c2b608dbb935c40855cedee8c0a

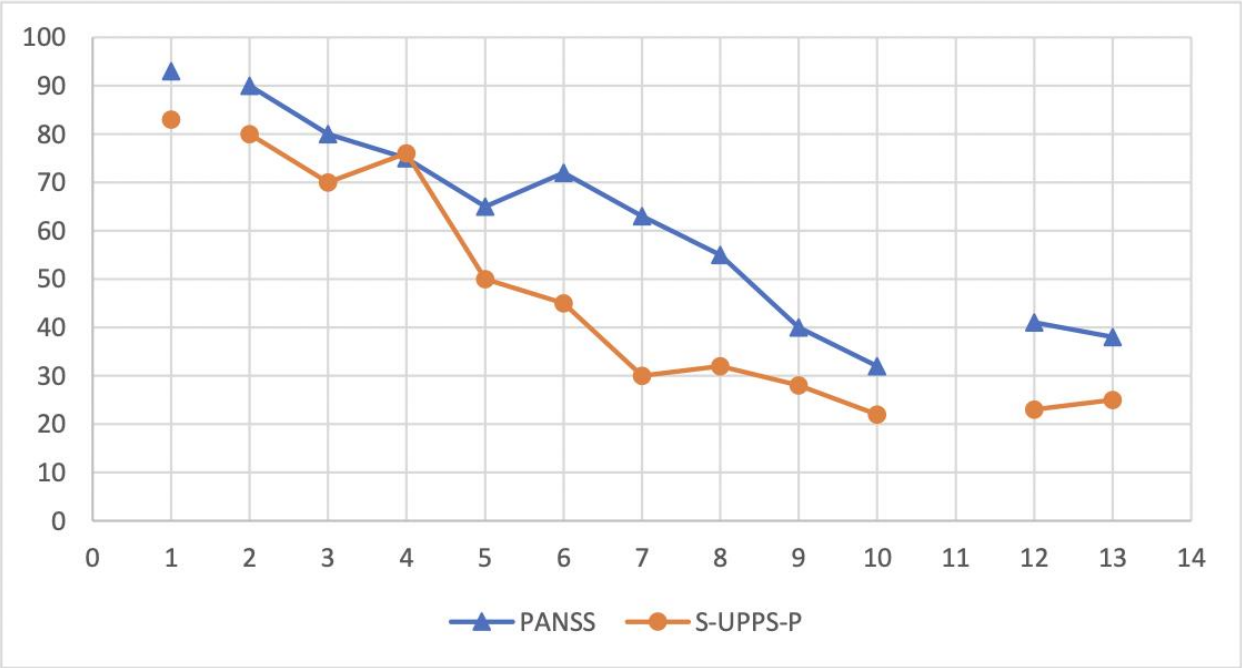
Appendix C

Hallucination Daily Log

Week of: March ___, 2026 (To be completed daily)

Please complete the log to the best of your ability to identify the occurrence of visual or auditory hallucinations throughout your day. Your social worker will review the responses with you during each weekly session. If you did experience any hallucinations for the day, please indicate that under type and description.

Date:	Time:	Type (Auditory, visual, other):	Description (explain what you saw or heard):	Intensity (Mild 1 – Severe 3)	Behavior Response:	Emotions (ex: happy, sad, confused):	Coping strategy:



ABA Design:

Blue triangle is baseline PANSS scores

Orange circle is baseline S-UPPS-P scores

Blue triangle line is PANSS intervention scores over time

Orange circle line is S-UPPS-P scores over time

Blue traingle scores are baseline PANSS scores post intervention

Orange circle scores are baseline S-UPPS-P scores post intervention