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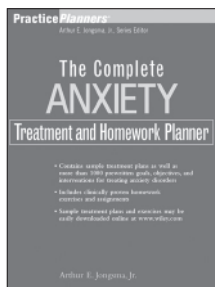
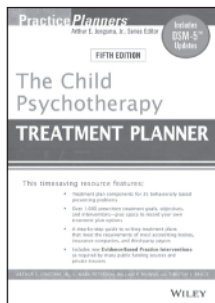
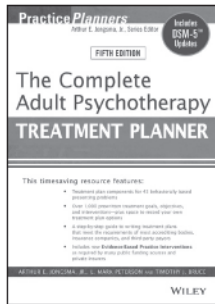
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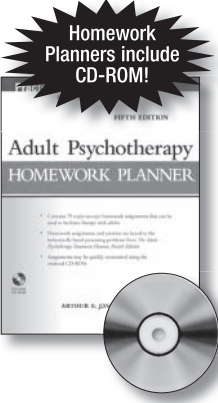
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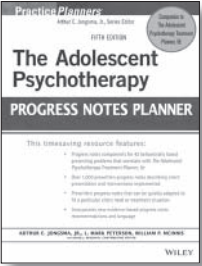
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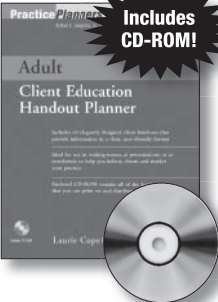
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Arthur E. Jongsma, Jr., Series Editor

The Complete Adult
Psychotherapy
Treatment Planner,
Fifth Edition

Arthur E. Jongsma, Jr.

L. Mark Peterson

Timothy J. Bruce

WILEY

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We dedicate this book to our most influential teachers and mentors early in our professional journey:

Dr. Solomon E. Feldman

Dr. Richard A. Westmaas

Dr. Richard Brown

Dr. Jack Carr

Dr. David H. Barlow

Dr. James Mancuso

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PRACTICEPLANNERS® SERIES PREFACE

Accountability is an important dimension of the practice of psychotherapy. Treatment programs, public agencies, clinics, and practitioners must justify and document their treatment plans to outside review entities in order to be reimbursed for services. The books and software in the *PracticePlanners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The *PracticePlanners*® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner*, *Child Psychotherapy Treatment Planner*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fifth editions, but also *Treatment Planners* targeted to specialty areas of practice, including:

- Addictions
- Co-occurring disorders
- Behavioral medicine
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
- Gays and lesbians
- Group therapy
- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders
- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work
- Severe and persistent mental illness
- Sexual abuse victims and offenders
- Social work and human services

- Special education
- Speech-Language pathology
- Suicide and homicide risk assessment
- Veterans and active military duty
- Women's issues

In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, substance use, anger control problems, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

ACKNOWLEDGMENTS

Since 2005 we have turned to research evidence to inform the treatment Objectives and Interventions in our latest editions of the *Psychotherapy Treatment Planner* books. While much of the content of our *Planners* was “best practice” and also from the mainstream of sound psychological procedure, we have benefited significantly from a thorough review that looked through the lens of evidence-based practice. The later editions of the *Planners* now stand as content not just based on “best practice” but based on reliable research results. Although several of my coauthors have contributed to this recertification of our content, Timothy J. Bruce has been the main guiding force behind this effort. I am very proud of the highly professional content provided by so many coauthors who are leaders in their respective subspecialties in the field of psychology such as addiction, family therapy, couples therapy, personality disorder treatment, group treatment, women’s issues, military personnel treatment, older adult treatment, and many others. Added to this expertise over the past 7 years has been the contribution of Dr. Tim Bruce who has used his depth of knowledge regarding evidence-supported treatment to shape and inform the content of the last two editions of *Adult, Adolescent, Child, and Addiction Psychotherapy Treatment Planners*. I welcome Tim aboard as an author for these books and consider it an honor to have him as a friend, colleague, and coauthor.

I must also add my acknowledgment of the supportive professionalism of the Wiley staff, especially that of my editor, Marquita Flemming. Wiley has been a trusted partner in this series for almost 20 years now and I am blessed to be published by such a highly respected company. Thank you to all my friends at Wiley!

And then there is our manuscript manager, Sue Rhoda, who knows just what to do to make a document presentable right up to the standards required by a publisher. Thank you, Sue.

Finally, I tip my hat to my coauthor, Mark Peterson, who launched this *Adult Psychotherapy Treatment Planner* with his original content contributions many years ago and has supported all the efforts to keep it fresh and evidence-based.

AEJ

I am fortunate to have been invited some seven years ago by Dr. Art Jongsma to work with him on his well-known and highly regarded *Psychotherapy Treatment Planner* series and now to be welcomed as one of his coauthors on this *Planner* along with Mark Peterson. As readers know, Art's treatment planners are highly regarded as works of enormous value to practicing clinicians as well as terrific educational tools for "students" of our profession. That Art's brainchild would have this type of value to our field is no surprise when you work with him. He is the consummate psychologist, with enormous breadth and depth of experience, a profound intellect, and a Rogerian capacity for empathy and understanding—all of which he would modestly deny. When you work with Art you not only get to know him, you get to know his family, colleagues, and friends. In doing so, you get to know his values. If you are like me, you have relationships that you prize because they are with people whom you know to be, simply stated, good. Well, to use an expression I grew up with, Art is good people. And it is my honor to have him as a friend, colleague, and coauthor. Thank you, Art!

I also would like thank Marquita Flemming and the staff at Wiley & Sons for their immeasurable support, guidance, and professionalism. It is just my opinion, but I think Marquita should publish her own book on author relations.

I would also like to extend a big thank-you to our manuscript manager, Sue Rhoda, for her exacting work and (needed) patience. In fact, I am sure Sue will take it in stride when we ask to do one more edit of this acknowledgment section after it has been "finalized."

Lastly, I would like thank my wife, Lori, and our children, Logan and Madeline, for all they do. They're good people, too.

TJB

The Complete Adult
Psychotherapy Treatment
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Fifth Edition

INTRODUCTION

ABOUT PRACTICE *PLANNERS*[®] TREATMENT PLANNERS

Pressure from third-party payors, accrediting agencies, and other outside parties has increased the need for clinicians to quickly produce effective, high-quality treatment plans. *Treatment Planners* provide all the elements necessary to quickly and easily develop formal treatment plans that satisfy the needs of most third-party payors and state and federal review agencies.

Each *Treatment Planner*:

- Saves you hours of time-consuming paperwork.
- Offers the freedom to develop customized treatment plans.
- Includes over 1,000 clear statements describing the behavioral manifestations of each relational problem, and includes long-term goals, short-term objectives, and clinically tested treatment options.
- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem.

As with the rest of the books in the *PracticePlanners*[®] series, our aim is to clarify, simplify, and accelerate the treatment planning process so you spend less time on paperwork and more time with your clients.

ABOUT THIS FIFTH EDITION *COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER*

This fifth edition of the *Complete Adult Psychotherapy Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based Objectives and Interventions
- Revised, expanded, and updated Appendix B: Professional References

2 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER

- Many more suggested homework assignments integrated into the Interventions
- Extensively expanded and updated self-help book list in Appendix A: Bibliotherapy Suggestions
- Appendix C: New Recovery Model listing Goals, Objectives, and Interventions allowing the integration of a recovery model orientation into treatment plans
- Addition of a chapter on Bipolar Disorder—Depression (former chapter on Depression has been renamed Unipolar Depression and Mania/Hypomania has been renamed Bipolar Disorder—Mania)
- Complete revision of the Cognitive Deficits chapter
- Integrated DSM-5 diagnostic labels and ICD-10-CM codes into the Diagnostic Suggestions section of each chapter
- Added Appendix D which provides an alphabetical index of the sources for assessment instruments and clinical interview forms cited in interventions

Evidence-based practice (EBP) is steadily becoming the standard of care in mental healthcare as it has in medical healthcare. Professional organizations such as the American Psychological Association, National Association of Social Workers, and the American Psychiatric Association, as well as consumer organizations such the National Alliance for the Mentally Ill (NAMI) have endorsed the use of EBP. In some practice settings, EBP is becoming mandated. It is clear that the call for evidence and accountability is being increasingly sounded. So, what is EBP and how is its use facilitated by this *Planner*?

Borrowing from the Institute of Medicine's definition (Institute of Medicine, 2001), the American Psychological Association (APA) has defined EBP as, "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006). Consistent with this definition, we have identified those psychological treatments with the best available supporting evidence, added Objectives and Interventions consistent with them in the pertinent chapters, and identified these with this symbol: ▽. As most practitioners know, research has shown that although these treatment methods have demonstrated efficacy (e.g., Nathan & Gorman, 2007), the individual psychologist (e.g., Wampold, 2001), the treatment relationship (e.g., Norcross, 2002), and the patient (e.g., Bohart & Tallman, 1999) are also vital contributors to the success of psychotherapy. As noted by the APA, "Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations" (APA, 2006, p. 275). For more information and instruction on constructing evidence-based psychotherapy treatment plans, see our DVD-based training series entitled *Evidence-based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

The sources listed in Appendix B: Professional References and used to identify the evidence-based treatments integrated into this *Planner* are many. They include supportive studies from the psychotherapy outcome literature, current expert individual, group, and organizational reviews, as well as evidence-based practice guideline recommendations. Examples of specific sources used include the Cochrane Collaboration reviews, the work of the Society of Clinical Psychology (Division 12 of the American Psychological Association) identifying research-supported psychological treatments, evidence-based treatment reviews such as those in Nathan and Gorman's *A Guide to Treatments That Work* and the Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Registry of Evidence-Based Programs and Practices* [NREPP], as well as evidence-based practice guidelines from professional organizations such as the American Psychiatric Association, the National Institute for Health and Clinical Excellence in Great Britain, the National Institute on Drug Abuse (NIDA), and the Agency for Healthcare Research and Quality (AHRQ) to name a few.

Although each of these sources uses its own criteria for judging levels of empirical support for any given treatment, we favored those that use more rigorous criteria typically requiring demonstration of efficacy through randomized controlled trials or clinical replication series, good experimental design, and independent replication. Our approach was to evaluate these various sources and include those treatments supported by the highest level of evidence and for which there was consensus in conclusions and recommendations. For any chapter in which EBP is identified, references to the sources used are listed in Appendix B: Professional References and can be consulted by those interested for further information regarding criteria and conclusions. In addition to these references, this appendix also includes references to Clinical Resources. Clinical Resources are books, manuals, and other resources for clinicians that describe the details of the application or "how to" of the treatment approaches described in a chapter.

There is debate regarding evidence-based practice among mental health professionals who are not always in agreement regarding the best treatment or how to weigh the factors that contribute to good outcomes. Some practitioners are skeptical about changing their practice on the basis of research evidence, and their reluctance is fueled by the methodological challenges and problems inherent in psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of treatment plan options, some supported by the evidence-based value of "best available research" (APA, 2006), others reflecting common clinical practices of experienced clinicians, and still others representing emerging approaches so the user can construct what they believe to be the best plan for their particular client.

Each of the chapters in this edition has also been reviewed with the goal of integrating homework exercise options into the Interventions. Many (but not all) of the client homework exercise suggestions were taken from and can be found in the *Adult Psychotherapy Homework Planner* (Jongsma,

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2014). You will find many more homework assignments suggested in this fifth edition of the *Complete Adult Psychotherapy Treatment Planner* than in previous editions.

The Bibliotherapy Suggestions Appendix A of this *Planner* has been significantly expanded and updated from previous editions. It includes many recently published offerings as well as more recent editions of books cited in our earlier editions. All of the self-help books and client workbooks cited in the chapter Interventions are listed in this appendix. There are also many additional books listed that are supportive of the treatment approaches described in the respective chapters. Each chapter has a list of self-help books consistent with its topic and listed in this appendix.

In its final report entitled *Achieving the Promise: Transforming Mental Health Care in America*, The President's New Freedom Commission on Mental Health called for recovery to be the "common, recognized outcome of mental health services" (New Freedom Commission on Mental Health, 2003). To define recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation (SAMHSA, 2004). Over 110 expert panelists participated including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation bodies, State and local public officials, and others. From these deliberations, the following consensus statement was derived:

Mental health recovery is a journey of healing and transformation for a person with a mental health problem to be able to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. Recovery is a multi-faceted concept based on the following 10 fundamental elements and guiding principles:

- Self-direction
- Individualized and person-centered
- Empowerment
- Holistic
- Nonlinear
- Strengths-based
- Peer support
- Respect
- Responsibility
- Hope

These principles are defined in Appendix C. We have also created a set of Goal, Objective, and Intervention statements that reflect these 10 principles.

The clinician who desires to insert into the client treatment plan specific statements reflecting a Recovery Model orientation may choose from this list.

In addition to this list, we believe that many of the Goal, Objective, and Intervention statements found in the chapters reflect a recovery orientation. For example, our assessment interventions are meant to identify how the problem affects this unique client and the strengths that the client brings to the treatment. Additionally, an intervention statement such as, “Review with the client the success he/she has had and the sources of love and concern that exist in his/her life,” from the Suicidal Ideation chapter, is evidence that recovery model content permeates items listed throughout our chapters. However, if the clinician desires a more focused set of statements directly related to each principle guiding the recovery model, they can be found in Appendix C.

We have done a bit of reorganizing of chapter content for this edition. We have renamed the Depression chapter as Unipolar Depression. This makes it distinct from the new chapter written for Bipolar Disorder—Depression. We also renamed the Mania/Hypomania chapter as Bipolar Disorder—Mania to be a companion to the Bipolar Disorder—Depression chapter. You will note that some of the content from the Bipolar Disorder—Depression chapter is repeated in the Bipolar Disorder—Mania chapter, but that the EBT symbol may or may not be present for the same content. This is done to indicate that the particular EBP has support for its efficacy on that particular chapter’s problem (e.g., symptoms of mania), but not necessarily on other aspects of the disorder (e.g., symptoms of bipolar depression). If more information is desired regarding the specific effects of any evidence-based treatment, one can find them by consulting the references to empirical support for that chapter in the Professional References Appendix. Finally, we have deleted the Chemical Dependence—Relapse chapter from this edition because the relapse issue is now adequately dealt with in the Substance Use chapter and most of the other components of the Relapse chapter were redundant with those in the Substance Use chapter.

The Cognitive Deficits chapter was thoroughly revised by an invited expert in the Rehabilitation Psychology field, Dr. Michele Rusin. Dr. Rusin has extensive experience in providing treatment for clients who present with cognitive deficits resulting from brain trauma or medical conditions. She is the primary author of the *Rehabilitation Psychology Treatment Planner*, one of the books in the *PracticePlanner* series. She has supplied guidance for the general practitioner in assessing and providing first-level treatment for mild cognitive deficits. Obviously, if more severe symptoms present themselves the client must be referred to a psychology and medical specialist for more in-depth therapy.

With the publication of the *DSM-5* (American Psychiatric Association [APA], 2013), we have updated the Diagnostic Suggestions listed at the end of each chapter. The *DSM-IV-TR* (APA, 2000) was used in previous editions of this *Planner*. Although many of the diagnostic labels and codes remain the

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same, several have changed with the publication of the *DSM-5* and are reflected in this *Planner*.

Some clinicians have asked that the Objective statements in this *Planner* be written such that the client's attainment of the Objective can be measured. We have written our Objectives in behavioral terms and many are measurable as written. For example, this Objective from the Anxiety chapter is one that is measurable as written because it either can be done or it cannot: "Verbalize an understanding of the role that cognitive biases play in excessive irrational worry and persistent anxiety symptoms." But at times the statements are too broad to be considered measurable. Consider, for example, this Objective from the Anxiety chapter: "Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk." To make it quantifiable a clinician might modify it to read, "Give two examples of identifying, challenging, and replacing biased, fearful self-talk with positive, realistic, and empowering self-talk." Clearly, the use of two examples is arbitrary, but it does allow for a quantifiable measurement of the attainment of the Objective. Or consider this example from the Anxiety chapter: "Identify and engage in pleasant activities on a daily basis." To make it more measurable the clinician might simply add a desired target number of pleasant activities, thus: "Identify and report engagement in two pleasant activities on a daily basis." The exact target number that the client is to attain is subjective and should be selected by the individual clinician in consultation with the client. Once the exact target number is determined, then our content can be very easily modified to fit the specific treatment situation. For more information on psychotherapy treatment plan writing, see Jongsma (2005).

Finally, we have added Appendix D which provides an alphabetical index of the sources for assessment instruments and clinical interview forms cited in interventions. We hope that this appendix allows the reader to find these resources easily if he/she wants to add them to a treatment plan.

We hope you find these improvements to this fifth edition of the *Planner* useful to your treatment planning needs.

HOW TO USE THIS TREATMENT PLANNER

Use this *Treatment Planner* to write treatment plans according to the following progression of six steps:

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal

with a few selected problems or treatment will lose its direction. Choose the problem within this *Planner* that most accurately represents your client's presenting issues.

2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-5* or the International Classification of Diseases. This *Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.
3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.
4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.
5. **Intervention Creation.** Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and strengths and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the provider to write other interventions reflecting his or her own training and experience.

Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix B contains a full bibliographic reference list of these materials, including these two popular choices: *Read Two Books and Let's Talk Next Week: Using Bibliotherapy in Clinical Practice* by Maidman, Joshua, and DiMenna and *Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy, Second Edition* by Hesley and Hesley (both books are published by Wiley). For further information about self-help books, mental health professionals may wish to consult the

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Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition (Norcross et al., 2003).

6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-5*. Despite arguments against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate implementation and presentation to the client. A sample treatment plan for Anxiety is provided at the end of this introduction.

A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing upon our own years of clinical experience and the best available research, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals whom they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. As with all of the books in the *Treatment Planner* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, clinician, and mental health community.

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SAMPLE TREATMENT PLAN

ANXIETY

- Definitions:** Excessive and/or unrealistic worry that is difficult to control occurring more days than not for at least 6 months about a number of events or activities.
Motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
Autonomic hyperactivity (e.g., palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, diarrhea).
Hypervigilance (e.g., feeling constantly on edge, experiencing concentration difficulties, having trouble falling or staying asleep, exhibiting a general state of irritability).
- Goals:** Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
Learn and implement coping skills that result in a reduction of anxiety and worry, and improved daily functioning.

OBJECTIVES

1. Describe situations, thoughts, feelings, and actions associated with anxieties and worries, their impact on functioning, and attempts to resolve them.
2. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment.

INTERVENTIONS

1. Focus on developing a level of trust with the client; provide support and empathy to encourage the client to feel safe in expressing his/her GAD symptoms.
2. Ask the client to describe his/her past experiences of anxiety and their impact on functioning; assess the focus, excessiveness, and uncontrollability of the worry and the type, frequency, intensity, and duration of his/her anxiety symptoms (consider using a structured interview such as *The Anxiety Disorders Interview Schedule—Adult Version*).
1. Discuss how generalized anxiety typically involves excessive worry about unrealistic threats, various bodily expressions of

tension, overarousal, and hypervigilance, and avoidance of what is threatening that interact to maintain the problem (see *Mastery of Your Anxiety and Worry—Therapist Guide* by Zinbarg, Craske, and Barlow; *Treating GAD* by Rygh and Sanderson).

2. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduce overarousal, and eliminate unnecessary avoidance.
 3. Assign the client to read psychoeducational sections of books or treatment manuals on worry and generalized anxiety (e.g., *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow; *Overcoming Generalized Anxiety Disorder* by White).
3. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms.
 1. Teach the client calming/relaxation skills (e.g., applied relaxation, progressive muscle relaxation, cue controlled relaxation; mindful breathing; biofeedback) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life (e.g., *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; *Treating GAD* by Rygh and Sanderson).
 2. Assign the client homework each session in which he/she practices relaxation exercises daily, gradually applying them

- progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success while providing corrective feedback toward improvement.
4. Learn and implement a strategy to limit the association between various environmental settings and worry, delaying the worry until a designated “worry time.”
 1. Explain the rationale for using a worry time as well as how it is to be used; agree upon a worry time with the client and implement.
 2. Teach the client how to recognize, stop, and postpone worry to the agreed-upon worry time using skills such as thought stopping, relaxation, and redirecting attention (or assign “Making Use of the Thought-Stopping Technique” and/or “Worry Time” in the *Adult Psychotherapy Homework Planner* by Jongsma to assist skill development); encourage use in daily life; review and reinforce success while providing corrective feedback toward improvement.
 5. Verbalize an understanding of the role that cognitive biases play in excessive irrational worry and persistent anxiety symptoms.
 1. Assist the client in analyzing his/her worries by examining potential biases such as the probability of the negative expectation occurring, the real consequences of it occurring, his/her ability to control the outcome, the worst possible outcome, and his/her ability to accept it (see “Analyze the Probability of a Feared Event” in the *Adult Psychotherapy Homework Planner* by Jongsma; *Cognitive Therapy of Anxiety Disorders* by Clark and Beck).

6. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk.
1. Explore the client's schema and self-talk that mediate his/her fear response; assist him/her in challenging the biases; replacing the distorted messages with reality-based alternatives and positive, realistic self-talk that will increase his/her self-confidence in coping with irrational fears (see *Cognitive Therapy of Anxiety Disorders* by Clark and Beck).
2. Assign the client a homework exercise in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

DIAGNOSIS

300.02 (F41.1)*

Generalized Anxiety Disorder

*ICD-9-CM Code (ICD-10-CM Code)

ANGER CONTROL PROBLEMS

BEHAVIORAL DEFINITIONS

1. Shows a pattern of episodic excessive anger in response to specific situations or situational themes.
2. Shows a pattern of general excessive anger across many situations.
3. Shows cognitive biases associated with anger (e.g., demanding expectations of others, overly generalized labeling of the targets of anger, anger in response to perceived “slights”).
4. Shows direct or indirect evidence of physiological arousal related to anger.
5. Reports a history of explosive, aggressive outbursts out of proportion with any precipitating stressors, leading to verbal attacks, assaultive acts, or destruction of property.
6. Displays overreactive verbal hostility to insignificant irritants.
7. Engages in physical and/or emotional abuse against significant other.
8. Makes swift and harsh judgmental statements to or about others.
9. Displays body language suggesting anger, including tense muscles (e.g., clenched fist or jaw), glaring looks, or refusal to make eye contact.
10. Shows passive-aggressive patterns (e.g., social withdrawal, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, uncooperative in meeting expected behavioral norms) due to anger.
11. Passively withholds feelings and then explodes in a rage.
12. Demonstrates an angry overreaction to perceived disapproval, rejection, or criticism.
13. Uses abusive language meant to intimidate others.
14. Rationalizes and blames others for aggressive and abusive behavior.
15. Uses aggression as a means of achieving power and control.

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LONG-TERM GOALS

1. Learn and implement anger management skills to reduce the level of anger and irritability that accompanies it.
2. Increase respectful communication through the use of assertiveness and conflict resolution skills.
3. Develop an awareness of angry thoughts, feelings, and actions, clarifying origins of, and learning alternatives to aggressive anger.
4. Decrease the frequency, intensity, and duration of angry thoughts, feelings, and actions and increase the ability to recognize and respectfully express frustration and resolve conflict.
5. Implement cognitive behavioral skills necessary to solve problems in a more constructive manner.
6. Come to an awareness and acceptance of angry feelings while developing better control and more serenity.
7. Become capable of handling angry feelings in constructive ways that enhance daily functioning.
8. Demonstrate respect for others and their feelings.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

1. Work cooperatively with the therapist to identify situations, thoughts, and feelings associated with anger, angry verbal and/or behavioral actions, and the targets of those actions. (1, 2)

1. Develop a level of trust with the client; provide support and empathy to encourage the client to feel safe in expressing his/her angry emotions as well as the impact anger expression has had

on his/her life as the interview focuses on the impact of anger on the client's life.

2. Complete psychological testing or objective questionnaires for assessing anger expression. (3)
3. Cooperate with a medical evaluation to assess possible medical conditions contributing to anger control problems. (4)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
2. As the client describes his/her history and nature of anger issues in his/her own words, thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
3. Administer to the client psychometric instruments designed to objectively assess anger expression (e.g., *Anger, Irritability, and Assault Questionnaire*; *Buss-Durkee Hostility Inventory*; *State-Trait Anger Expression Inventory*); give the client feedback regarding the results of the assessment; re-administer as indicated to assess treatment response.
4. Refer the client to a physician for a complete medical evaluation to rule out medical conditions or substances possibly causing or contributing to the anger control problems (e.g., brain damage, tumor, elevated testosterone levels, stimulant use).
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change;

demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Cooperate with a medication evaluation for possible treatment
9. Assess the client for the need and willingness to take psychotropic



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with psychotropic medications to assist in anger control; take medications consistently, if prescribed. (9, 10)

medication to assist in control of anger; refer him/her to a physician for an evaluation and prescription of medication, if needed. ▽

- ▽ 6. Keep a daily journal of persons, situations, and other triggers of anger; record thoughts, feelings, and actions taken. (11, 12)
- ▽ 7. Verbalize increased awareness of anger expression patterns, their causes, and their consequences. (13, 14, 15, 16)
10. Monitor the client for prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician. ▽
11. Ask the client to self-monitor, keeping a daily journal in which he/she documents persons, situations, thoughts, feelings, and actions associated with moments of anger, irritation, or disappointment (or assign “Anger Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma); routinely process the journal toward helping the client understand his/her contributions to generating his/her anger. ▽
12. Assist the client in generating a list of anger triggers; process the list toward helping the client understand the causes and expressions of his/her anger. ▽
13. Assist the client in re-conceptualizing anger as involving different dimensions (cognitive, physiological, affective, and behavioral) that interact predictably (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out) and that can be understood, challenged, and changed. ▽
14. Process the client’s list of anger triggers and other relevant

journal information toward helping the client understand how cognitive, physiological, and affective factors interplay to produce anger. ▽

15. Ask the client to list and discuss ways anger has negatively impacted his/her daily life (e.g., hurting others or self, legal conflicts, loss of respect from self and others, destruction of property); process this list. ▽
 16. Assist the client in identifying the positive consequences of managing anger (e.g., respect from others and self, cooperation from others, improved physical health, etc.) (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
 17. Use motivational interviewing techniques to help the client clarify his/her motivational stage, moving the client to the action stage in which he/she agrees to learn new ways to conceptualize and manage anger. ▽
 18. Discuss the rationale for treatment, emphasizing how functioning can be improved through change in the various dimensions of anger; revisit relevant themes throughout therapy to help the client consolidate his/her understanding. ▽
 19. Assign the client reading material that educates him/her about anger and its management (e.g., *Overcoming Situational and General Anger: Client Manual* by
- ▽ 8. Explore motivation and willingness to participate in therapy, and agree to participate to learn new ways to think about and manage anger. (17)
 - ▽ 9. Verbalize an understanding of how the treatment is designed to decrease anger and improve the quality of life. (18)
 - ▽ 10. Read a book or treatment manual that supplements the therapy by improving understanding of anger and anger control problems. (19)

Deffenbacher and McKay; *Of Course You're Angry* by Rosselini and Worden; *The Anger Control Workbook* by McKay and Rogers; *Anger Management for Everyone* by Kassonov and Tafrate); process and revisit relevant themes throughout therapy to help the client consolidate his/her understanding of the treatment. ▽

- ▽ 11. Learn and implement calming and coping strategies as part of an overall approach to managing anger. (20)
- ▽ 12. Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a less angry reaction. (21, 22, 23)
- 20. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation, mindful breathing) as part of a tailored strategy for reducing chronic and acute physiological tension that accompanies the escalation of his/her angry feelings. ▽
- 21. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should*, *must*, or *have-to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration. Combine new self-talk with calming skills as part of a set of coping skills to manage anger. ▽
- 22. Assign the client a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions; review; reinforce success,

providing corrective feedback toward improvement. ▽

13. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger. (24)
- ▽ 14. Verbalize an understanding of assertive communication and how it can be used to express thoughts and feelings of anger in a controlled, respectful way. (25)
- ▽ 15. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems. (26, 27, 28)
23. Role-play the use of relaxation and cognitive coping to visualized anger-provoking scenes, moving from low- to high-anger scenes. Assign the implementation of calming techniques in his/her daily life and when facing anger-triggering situations; process the results, reinforcing success and problem-solving obstacles. ▽
24. Assign the client to implement a “thought-stopping” technique in which he/she shouts STOP to himself/herself in his/her mind and then replaces the thought with an alternative that is calming (or assign “Making Use of the Thought-Stopping Technique” in the *Adult Psychotherapy Homework Planner* by Jongsma); review implantation, reinforcing success and providing corrective feedback for failure.
25. Use instruction, modeling, and/or role-playing to teach the client the distinctive elements as well as the pros and cons of assertive, unassertive (passive), and aggressive communication. ▽
26. Teach the client problem-solving skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating the outcome, and readjusting the plan as necessary). ▽

- ▼^{EB} 16. Practice using new anger management skills in session with the therapist and during homework exercises. (29, 30, 31)
- ▼^{EB} 17. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (32)
27. Teach the client conflict resolution skills (e.g., empathy, active listening, “I messages,” respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts. ▼^{EB}
28. Conduct conjoint sessions to help the client implement assertion, problem-solving, and/or conflict resolution skills in the presence of his/her significant other. ▼^{EB}
29. Assist the client in constructing a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs. ▼^{EB}
30. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing anger. ▼^{EB}
31. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or *in vivo* exposure/behavioral experiments to help the client consolidate the use of his/her new anger management skills. ▼^{EB}
32. Monitor the client’s reports of angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the client’s use of new anger management skills (or assign “Alternatives to Destructive Anger” in the *Adult*

Psychotherapy Homework Planner by Jongsma); review progress, reinforcing success and providing corrective feedback toward improvement. ▽

- ▽ 18. Verbalize an understanding of relapse prevention and the difference between a lapse and relapse. (33, 34)
- ▽ 19. Identify potential situations that could trigger a lapse and implement strategies to manage these situations. (35, 36, 37, 38)
- 33. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it. ▽
- 34. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible angry outburst and relapse with the choice to return routinely to the old pattern of anger. ▽
- 35. Identify and rehearse with the client the management of future situations or circumstances in which lapses back to anger could occur. ▽
- 36. Instruct the client to routinely use the new anger management strategies learned in therapy (e.g., calming, adaptive self-talk, assertion, and/or conflict resolution) to respond to frustrations. ▽
- 37. Develop a “coping card” or other reminder on which new anger management skills and other important information (e.g., calm yourself, be flexible in your expectations of others, voice your opinion calmly, respect others’ point of view) are recorded for the client’s later use. ▽
- 38. Schedule periodic “maintenance” sessions to help the client maintain therapeutic gains. ▽

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20. Identify the advantages and disadvantages of holding on to anger and of forgiveness; discuss with therapist. (39, 40)
21. Write a letter of forgiveness to the perpetrator of past or present pain and process this letter with the therapist. (41)
22. Participate in Acceptance and Commitment Therapy (ACT) for learning a new approach to anger and anger management. (42, 43, 44, 45)
39. Discuss with the client forgiveness of the perpetrators of pain as a process of letting go of his/her anger.
40. Assign the client to read *Forgive and Forget* by Smedes; process the content as to how it applies to the client's own life.
41. Ask the client to write a forgiving letter to the target of anger as a step toward letting go of anger; process this letter in session.
42. Use an ACT approach to help the client experience and accept the presence of worrisome thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
43. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing but not reacting to non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabats-Zinn).
44. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

- 23. Gain insight into the origins of anger control problems by discussing past relationships with significant others. (46)
 - 24. Identify social supports that will help facilitate the implementation of anger management skills. (47)
 - 45. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy* by Hayes).
 - 46. Assist the client in identifying past relationship conflicts (e.g., with father, mother, others) that may have influenced the development of current anger control problems; discuss how these experiences have positively or negatively influenced the way he/she handles anger.
 - 47. Encourage the client to discuss his/her anger management goals with trusted persons who are likely to support his/her change.
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.34	Intermittent Explosive Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.8	Conduct Disorder
	310.1	Personality Change Due to Axis III Disorder
	309.81	Posttraumatic Stress Disorder

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V61.12	Physical Abuse of Adult (by Partner)
V61.83	Physical Abuse of Adult (by non-Partner)

Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
312.34	F63.81	Intermittent Explosive Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
312.8	F91.x	Conduct Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition
309.81	F43.10	Posttraumatic Stress Disorder
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
V62.83	Z69.82	Encounter for Mental Health Services for Perpetrator of Nonspousal Adult Abuse
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

ANTISOCIAL BEHAVIOR

BEHAVIORAL DEFINITIONS

1. An adolescent history of consistent rule-breaking, lying, stealing, physical aggression, disrespect for others and their property, and/or substance abuse resulting in frequent confrontation with authority.
2. Failure to conform with social norms with respect to the law, as shown by repeatedly performed antisocial acts (e.g., destroying property, stealing, pursuing an illegal job) for which he/she may or may not have been arrested.
3. Pattern of interacting in an angry, confrontational, aggressive, and/or argumentative way with authority figures.
4. Consistently uses alcohol or other mood-altering drugs until high, intoxicated, or passed out.
5. Little or no remorse for causing pain to others.
6. Consistent pattern of blaming others for what happens to him/her.
7. Little regard for truth, as reflected in a pattern of consistently lying to and/or conning others.
8. Frequent angry initiation of verbal or physical fighting.
9. History of reckless behaviors that reflect a lack of regard for self or others and show a high need for excitement, fun, and living on the edge.
10. Pattern of sexual promiscuity; has never been totally monogamous in any relationship for a year and does not take responsibility for children resulting from relationships.
11. Pattern of impulsive behaviors, such as moving often, traveling with no goal, or quitting a job without having secured another one.
12. Inability to sustain behavior that would maintain consistent employment.
13. Failure to function as a consistently concerned and responsible parent.

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LONG-TERM GOALS

1. Accept responsibility for own behavior and keep behavior within the acceptable limits of the rules of society.
2. Develop and demonstrate a healthy sense of respect for social norms, the rights of others, and the need for honesty.
3. Improve method of relating to the world, especially authority figures; be more realistic, less defiant, and more socially sensitive.
4. Come to an understanding and acceptance of the need for conforming to prevailing social limits and boundaries on behavior.
5. Maintain consistent employment and demonstrate financial and emotional responsibility for children.
6. Embrace the recovery model’s emphasis on accepting responsibility for treatment decisions as well as the expectation of being able to live, work, and participate fully in the community.

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SHORT-TERM OBJECTIVES

1. Admit to illegal and/or unethical behavior that has trampled on the law and/or the rights and feelings of others. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Explore the history of the client’s pattern of illegal and/or unethical behavior and confront his/her attempts at minimization, denial, or projection of blame while showing how the client’s own thinking pattern leads to illegal behavior (or assign “Crooked Thinking Leads to Crooked Behavior” or “Accept

Responsibility for Illegal Behavior” from the *Adult Psychotherapy Homework Planner* by Jongsma).

2. Provide honest and complete information for a Substance Use history. (3)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)
2. Review the consequences for the client and others of his/her antisocial behavior.
3. Assess the client for the presence of chemical dependence and refer for focused substance abuse treatment if warranted (see the Substance Use chapter in this *Planner*).
4. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
6. Assess for any issues of age, gender, or culture that could

help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 8. Using a directive, client-centered, empathic style derived from motivational enhancement therapy (see *Motivational Interviewing* by Miller and Rollnick; and *Addiction and Change* by DiClemente), establish rapport with the client and listen reflectively, asking permission before providing information or advice.
 9. Ask open-ended questions to explore the client's own motivations for change, affirming his or her change-related statements and efforts (see *Substance Abuse Treatment and the Stages of Change* by Connors, Donovan, and DiClemente).
 10. Elicit recognition of the discrepancy gap between current behavior and desired life goals,
4. Explore and resolve ambivalence associated with commitment to change behaviors related to antisocial behavior pattern, including substance abuse if present. (8, 9, 10)

- reflecting resistance without direct confrontation or argumentation.
5. Verbalize an understanding of the benefits for self and others of living within the laws and rules of society. (11, 12)
 6. Make a commitment to live within the rules and laws of society. (13, 14)
 7. List relationships that have been broken because of disrespect, disloyalty, aggression, or dishonesty. (15)
 8. Acknowledge a pattern of self-centeredness in virtually all relationships. (16, 17)
 9. Make a commitment to be honest and reliable. (18, 19, 20)
 11. Teach the client that the basis for all relationships is trust that the other person will treat one with respect and kindness.
 12. Teach the client the need for lawfulness as the basis for trust that forestalls anarchy in society as a whole.
 13. Solicit a commitment from the client to conform to a prosocial, law-abiding lifestyle.
 14. Emphasize the reality of negative consequences for the client if he/she continues to practice lawlessness.
 15. Review relationships that have been lost due to the client's antisocial attitudes and practices (e.g., disloyalty, dishonesty, aggression).
 16. Confront the client's lack of sensitivity to the needs and feelings of others.
 17. Point out the self-focused, me-first, look-out-for-number-one attitude that is reflected in the client's antisocial behavior.
 18. Teach the client the value for self of honesty and reliability in all relationships, since he/she benefits from social approval as well as increased trust and respect.
 19. Teach the client the positive effect that honesty and reliability have for others, since they are not disappointed or hurt by lies and broken promises.

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10. Verbalize an understanding of the benefits to self and others of being empathetic and sensitive to the needs of others. (11, 21, 22)
11. List three actions that will be performed that will be acts of kindness and thoughtfulness toward others. (23)
12. Indicate the steps that will be taken to make amends or restitution for hurt caused to others. (24, 25, 26)
20. Ask the client to make a commitment to be honest and reliable.
11. Teach the client that the basis for all relationships is trust that the other person will treat one with respect and kindness.
21. Attempt to sensitize the client to his/her lack of empathy for others by revisiting the consequences of his/her behavior on others; use role reversal techniques.
22. Confront the client when he/she is rude or not being respectful of others and their boundaries.
23. Assist the client in listing three actions that he/she will perform as acts of service or kindness for others.
24. Assist the client in identifying those who have been hurt by his/her antisocial behavior (or assign “How I Have Hurt Others” from the *Adult Psychotherapy Homework Planner* by Jongsma).
25. Teach the client the value of apologizing for hurt caused as a means of accepting responsibility for behavior and of developing sensitivity to the feelings of others.
26. Encourage the client’s commitment to specific steps that will be taken to apologize and make restitution to those who have suffered from his/her hurtful behaviors (or assign “Letter of Apology” from the *Adult Psychotherapy Homework Planner* by Jongsma).

13. Verbally demonstrate an understanding of the rules and duties related to employment. (27)
14. Attend work reliably and treat supervisors and coworkers with respect. (28, 29)
15. Verbalize the obligations of parenthood that have been ignored. (30, 31)
16. State a plan to meet responsibilities of parenthood. (32)
17. Increase statements of accepting responsibility for own behavior. (33, 34, 35)
27. Review the rules and expectations that must govern the client's behavior in the work environment.
28. Monitor the client's attendance at work and reinforce reliability as well as respect for authority.
29. Ask the client to make a list of behaviors and attitudes that must be modified in order to decrease his/her conflict with authorities; process the list.
30. Confront the client's avoidance of responsibilities toward his/her children.
31. Assist the client in listing the behaviors that are required to be a responsible, nurturing, and consistently reliable parent.
32. Develop a plan with the client that will begin to implement the behaviors of a responsible parent.
33. Confront the client when he/she makes blaming statements or fails to take responsibility for own actions, thoughts, or feelings (or assign "Accept Responsibility for Illegal Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).
34. Explore the client's reasons for blaming others for his/her own actions (e.g., history of physically abusive punishment, parental modeling, fear of rejection, shame, low self-esteem, avoidance of facing consequences).
35. Give verbal positive feedback to the client when he/she takes responsibility for his/her own behavior.

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18. Verbalize an understanding of how childhood experiences of pain have led to an imitative pattern of self-focused protection and aggression toward others. (36, 37)
19. Identify situations, thoughts, and feelings that trigger anger, angry verbal and/or aggressive behavioral actions. (38)
20. Complete psychological testing or objective questionnaires for assessing anger expression. (39)
36. Explore the client's history of abuse, neglect, or abandonment in childhood (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma); explain how the cycle of abuse or neglect is repeating itself in the client's behavior.
37. Point out that the client's pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect self from pain.
38. As the client describes his/her history and nature of anger issues in his/her own words, thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and aggressive actions that have characterized his/her anger responses (consider assigning the exercise "Anger Journal" from the *Adult Psychotherapy Homework Planner* by Jongsma).
39. Administer to the client psychological instruments designed to objectively assess anger expression (e.g., *Anger, Irritability, and Assault Questionnaire*; *Buss-Durkee Hostility Inventory*; *State-Trait Anger Expression Inventory*); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.

21. Learn and implement calming and coping strategies as part of an overall approach to managing anger. (40, 41)
22. Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a less angry reaction. (42, 43)
40. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing-induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation) as part of a tailored strategy for reducing chronic and acute physiological tension that accompanies his/her angry feelings.
41. Role-play the use of relaxation and cognitive coping to visualized anger-provoking scenes, moving from low- to high-anger scenes. Assign the implementation of calming techniques in his/her daily life when facing anger trigger situations; process the results, reinforcing success and problem-solving obstacles.
42. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should*, *must*, or *have-to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration. Combine new self-talk with calming skills as part of developing coping skills for managing anger.
43. Assign the client a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions; review while reinforcing success, providing corrective feedback toward improvement.

- 23. Verbalize a list of constructive alternatives to aggressive anger in response to trigger situations. (44)
- 24. Verbalize a desire to forgive perpetrators of childhood abuse. (45)
- 25. Practice trusting a significant other with disclosure of personal feelings. (46, 47, 48)
- 44. Review with the client alternatives (e.g., assertiveness, relaxation, diversion, calming self-talk, etc.) to destructive anger in response to trigger situations; role-play the application of some of these alternatives to real life situations (or assign “Alternatives to Destructive Anger” from the *Adult Psychotherapy Homework Planner* by Jongsma).
- 45. Teach the client the value of forgiving the perpetrators of hurt versus holding on to hurt and rage and using the hurt as an excuse to continue antisocial practices.
- 46. Explore the client’s fears associated with placing trust in others.
- 47. Identify some personal thoughts and feelings that the client could share with a significant other as a means of beginning to demonstrate trust in someone.
- 48. Process the experience of the client making himself/herself vulnerable by self-disclosing to someone.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	304.20	Cocaine Dependence
	304.80	Polysubstance Dependence
	312.8	Conduct Disorder
	312.34	Intermittent Explosive Disorder
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Axis II:	301.7	Antisocial Personality Disorder
	301.81	Narcissistic Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
312.8	F91.x	Conduct Disorder
312.34	F63.81	Intermittent Explosive Disorder
301.7	F60.2	Antisocial Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

ANXIETY

BEHAVIORAL DEFINITIONS

1. Excessive and/or unrealistic worry that is difficult to control occurring more days than not for at least 6 months about a number of events or activities.
2. Motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
3. Autonomic hyperactivity (e.g., palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, diarrhea).
4. Hypervigilance (e.g., feeling constantly on edge, experiencing concentration difficulties, having trouble falling or staying asleep, exhibiting a general state of irritability).

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LONG-TERM GOALS

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Stabilize anxiety level while increasing ability to function on a daily basis.
3. Resolve the core conflict that is the source of anxiety.
4. Enhance ability to effectively cope with the full variety of life's worries and anxieties.
5. Learn and implement coping skills that result in a reduction of anxiety and worry, and improved daily functioning.

SHORT-TERM OBJECTIVES

1. Describe situations, thoughts, feelings, and actions associated with anxieties and worries, their impact on functioning, and attempts to resolve them. (1, 2)

2. Complete psychological tests designed to assess worry and anxiety symptoms. (3)

3. Complete a medical evaluation to assess for possible contribution of medical or substance-related conditions to the anxiety. (4)

THERAPEUTIC INTERVENTIONS

1. Focus on developing a level of trust with the client; provide support and empathy to encourage the client to feel safe in expressing his/her GAD symptoms.

2. Ask the client to describe his/her past experiences of anxiety and their impact on functioning; assess the focus, excessiveness, and uncontrollability of the worry and the type, frequency, intensity, and duration of his/her anxiety symptoms (consider using a structured interview such as *The Anxiety Disorders Interview Schedule-Adult Version*).

3. Administer psychological tests or objective measures to help assess the nature and degree of the client’s worry and anxiety and their impact on functioning (e.g., *The Penn State Worry Questionnaire*; *OQ-45.2*; the *Symptom Checklist-90-R*).

4. Refer the client to a physician for a medical evaluation to rule out general medical or substance-related causes of the GAD.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment

- (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼ 5. Cooperate with a medication evaluation by a physician. (9, 10)
 - ▼ 6. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment. (11, 12, 13)
 - 9. Refer the client to a physician for a psychotropic medication consultation. ▼
 - 10. Monitor the client's psychotropic medication compliance, side effects, and effectiveness; confer regularly with the physician. ▼
 - 11. Discuss how generalized anxiety typically involves excessive worry about unrealistic threats, various bodily expressions of tension, overarousal, and hypervigilance, and avoidance of what is threatening that interact to maintain the problem (see *Mastery of Your Anxiety and Worry: Therapist Guide* by Zinbarg, Craske, and Barlow; *Treating Generalized Anxiety Disorder* by Rygh and Sanderson). ▼
 - 12. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduce overarousal, and eliminate unnecessary avoidance. ▼
 - 13. Assign the client to read psychoeducational sections of books or treatment manuals on worry and generalized anxiety (e.g., *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow; *Overcoming Generalized Anxiety Disorder* by White). ▼

- ▽^{EB} 7. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (14, 15, 16)
14. Teach the client calming/relaxation skills (e.g., applied relaxation, progressive muscle relaxation, cue controlled relaxation; mindful breathing; biofeedback) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life (e.g., *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; *Treating Generalized Anxiety Disorder* by Rygh and Sanderson). ▽^{EB}
15. Assign the client homework each session in which he/she practices relaxation exercises daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success while providing corrective feedback toward improvement. ▽^{EB}
16. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec; *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow). ▽^{EB}
- ▽^{EB} 8. Learn and implement a strategy to limit the association between various environmental settings and worry, delaying the worry until a designated “worry time.” (17, 18)
17. Explain the rationale for using a worry time as well as how it is to be used; agree upon and implement a worry time with the client. ▽^{EB}
18. Teach the client how to recognize, stop, and postpone worry to the agreed upon worry time using skills such as thought

stopping, relaxation, and redirecting attention (or assign “Making Use of the Thought-Stopping Technique” and/or “Worry Time” in the *Adult Psychotherapy Homework Planner* by Jongsma to assist skill development); encourage use in daily life; review and reinforce success while providing corrective feedback toward improvement. ▾

- ▾ 9. Verbalize an understanding of the role that cognitive biases play in excessive irrational worry and persistent anxiety symptoms. (19, 20, 21)
19. Discuss examples demonstrating that unrealistic worry typically overestimates the probability of threats and underestimates or overlooks the client’s ability to manage realistic demands (or assign “Past Successful Anxiety Coping” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▾
20. Assist the client in analyzing his/her worries by examining potential biases such as the probability of the negative expectation occurring, the real consequences of it occurring, his/her ability to control the outcome, the worst possible outcome, and his/her ability to accept it (see “Analyze the Probability of a Feared Event” in the *Adult Psychotherapy Homework Planner* by Jongsma; *Cognitive Therapy of Anxiety Disorders* by Clark and Beck). ▾
21. Help the client gain insight into the notion that worry may function as a form of avoidance of a feared problem and that it creates acute and chronic tension. ▾

- ▽^{EB} 10. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (22, 23)
22. Explore the client's schema and self-talk that mediate his/her fear response; assist him/her in challenging the biases; replace the distorted messages with reality-based alternatives and positive, realistic self-talk that will increase his/her self-confidence in coping with irrational fears (see *Cognitive Therapy of Anxiety Disorders* by Clark and Beck). ▽^{EB}
23. Assign the client a homework exercise in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. ▽^{EB}
- ▽^{EB} 11. Undergo gradual repeated imaginal exposure to the feared negative consequences predicted by worries and develop alternative reality-based predictions. (24, 25, 26, 27)
24. Direct and assist the client in constructing a hierarchy of two to three spheres of worry for use in exposure (e.g., worry about harm to others, financial difficulties, relationship problems). ▽^{EB}
25. Select initial exposures that have a high likelihood of being a success experience for the client; develop a plan for managing the negative effect engendered by exposure; mentally rehearse the procedure. ▽^{EB}
26. Ask the client to vividly imagine worst-case consequences of worries, holding them in mind until anxiety associated with them weakens (up to 30 minutes);

generate reality-based alternatives to that worst case and process them (see *Mastery of Your Anxiety and Worry: Therapist Guide* by Zinbarg, Craske, and Barlow).^{EB}▽

- ▽^{EB} 12. Learn and implement problem-solving strategies for realistically addressing worries. (28, 29)
27. Assign the client a homework exercise in which he/she does worry exposures and records responses (see *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow or *Generalized Anxiety Disorder* by Brown, O’Leary, and Barlow); review, reinforce success, and provide corrective feedback toward improvement.^{EB}▽
28. Teach the client problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating the pros and cons of each option, selecting and implementing an optional action, and reevaluating and refining the action (or assign “Applying Problem-Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
29. Assign the client a homework exercise in which he/she problem-solves a current problem (see *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow or *Generalized Anxiety Disorder* by Brown, O’Leary, and Barlow); review, reinforce success, and provide corrective feedback toward improvement.^{EB}▽
- ▽^{EB} 13. Identify and engage in pleasant activities on a daily basis. (30)
30. Engage the client in behavioral activation, increasing the client’s contact with sources of reward,

identifying processes that inhibit activation, and teaching skills to solve life problems (or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, role reversal as needed to assist adoption into the client’s daily life; reinforce success. ▾

▾ 14. Learn and implement personal and interpersonal skills to reduce anxiety and improve interpersonal relationships. (31, 32)

31. Use instruction, modeling, and role-playing to build the client’s general social, communication, and/or conflict resolution skills. ▾

32. Assign the client a homework exercise in which he/she implements communication skills training into his/her daily life (or assign “Restoring Socialization Comfort” in the *Adult Psychotherapy Homework Planner* by Jongsma); review, reinforce success, and provide corrective feedback toward improvement. ▾

▾ 15. Learn and implement relapse prevention strategies for managing possible future anxiety symptoms. (33, 34, 35, 36, 37)

33. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of worry, anxiety symptoms, or urges to avoid, and relapse with the decision to continue the fearful and avoidant patterns. ▾

34. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. ▾

35. Instruct the client to routinely use new therapeutic skills (e.g.,

- relaxation, cognitive restructuring, exposure, and problem-solving) in daily life to address emergent worries, anxiety, and avoidant tendencies. ▽
16. Learn to accept limitations in life and commit to tolerating, rather than avoiding, unpleasant emotions while accomplishing meaningful goals. (38)
 17. Utilize a paradoxical intervention technique to reduce the anxiety response. (39)
 18. Complete a Cost Benefit Analysis of maintaining the anxiety. (40)
 36. Develop a “coping card” on which coping strategies and other important information (e.g., “Breathe deeply and relax,” “Challenge unrealistic worries,” “Use problem-solving”) are written for the client’s later use. ▽
 37. Schedule periodic “maintenance” sessions to help the client maintain therapeutic gains. ▽
 38. Use techniques from Acceptance and Commitment Therapy to help client accept uncomfortable realities such as lack of complete control, imperfections, and uncertainty and tolerate unpleasant emotions and thoughts in order to accomplish value-consistent goals.
 39. Develop a paradoxical intervention (see *Ordeal Therapy* by Haley) in which the client is encouraged to have the problem (e.g., anxiety) and then schedule that anxiety to occur at specific intervals each day (at a time of day/night when the client would be clearly wanting to do something else) in a specific way and for a defined length of time.
 40. Ask the client to evaluate the costs and benefits of worries (e.g., complete the Cost Benefit Analysis exercise in *Ten Days to Self-Esteem!* by Burns) in which he/she lists the advantages and disadvantages of the negative

19. Identify the major life conflicts from the past and present that form the basis for present anxiety. (41, 42, 43)
20. Maintain involvement in work, family, and social activities. (44)
21. Reestablish a consistent sleep-wake cycle. (45)
41. Assist the client in becoming aware of key unresolved life conflicts and in starting to work toward their resolution.
42. Reinforce the client's insights into the role of his/her past emotional pain and present anxiety.
43. Ask the client to develop and process a list of key past and present life conflicts that continue to cause worry.
44. Support the client in following through with work, family, and social activities rather than escaping or avoiding them to focus on anxiety.
45. Teach and implement sleep hygiene practices to help the client reestablish a consistent sleep-wake cycle; review, reinforce success, and provide corrective feedback toward improvement.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.02	Generalized Anxiety Disorder
	300.00	Anxiety Disorder NOS
	309.24	Adjustment Disorder With Anxiety

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.02	F41.1	Generalized Anxiety Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
309.24	F43.22	Adjustment Disorder, With Anxiety

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

ATTENTION DEFICIT DISORDER (ADD)—ADULT

BEHAVIORAL DEFINITIONS

1. Childhood history of Attention Deficit Disorder (ADD) that was either diagnosed or later concluded due to the symptoms of behavioral problems at school, impulsivity, temper outbursts, and lack of concentration.
2. Unable to concentrate or pay attention to things of low interest, even when those things are important to his/her life.
3. Easily distracted and drawn from task at hand.
4. Restless and fidgety; unable to be sedentary for more than a short time.
5. Impulsive; has an easily observable pattern of acting first and thinking later.
6. Rapid mood swings and mood lability within short spans of time.
7. Disorganized in most areas of his/her life.
8. Starts many projects but rarely finishes any.
9. Has a “low boiling point” and a “short fuse.”
10. Exhibits low stress tolerance; is easily frustrated, hassled, or upset.
11. Chronic low self-esteem.
12. Tendency toward addictive behaviors.

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LONG-TERM GOALS

1. Reduce impulsive actions while increasing concentration and focus on low-interest activities.
2. Minimize ADD behavioral interference in daily life.
3. Accept ADD as a chronic issue and need for continuing medication treatment.
4. Sustain attention and concentration for consistently longer periods of time.
5. Achieve a satisfactory level of balance, structure, and intimacy in personal life.

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SHORT-TERM OBJECTIVES

1. Describe past and present experiences with ADD including its effects on functioning. (1, 2)

2. Cooperate with and complete psychological testing. (3)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Conduct a thorough psychosocial assessment including past and present symptoms of ADD and their effects on educational, occupational, and social functioning.
3. Conduct or arrange for psychological testing to further assess ADD, other possible psychopathology (e.g., anxiety, depression), and relevant rule-outs (e.g., ADHD, conduct/antisocial features); provide feedback of testing results.

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3. Cooperate with and complete a psychiatric evaluation. (4)
4. Arrange for a psychiatric evaluation of the client to rule out medical and substance-related etiologies and assess his/her need for psychotropic medication.
4. Comply with all recommendations based on the psychiatric and/or psychological evaluations. (5, 6)
5. Process the results of the psychiatric evaluation and/or psychological testing with the client and answer any questions that may arise.
5. Disclose any history of substance use that may contribute to and complicate the treatment of ADD. (7)
6. Conduct a conjoint session with significant others and the client to present the results of the psychological and psychiatric evaluations; answer any questions they may have and solicit their support in dealing with the client's condition.
6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)
7. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
8. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
7. Take psychotropic medication as prescribed, on a regular, consistent basis. (12, 13)
12. Monitor and evaluate the client's psychotropic medication prescription compliance, side effects, and the effectiveness of the medications on his/her level of functioning.
13. Confer with the client's psychiatrist on a regular basis regarding the effectiveness and side effects of the medication regimen.

8. Identify specific benefits of taking prescribed psychotropic medications on a long-term basis. (14, 15)
9. Identify the current specific ADD behaviors that cause the most difficulty. (16, 17, 18)
10. List the negative consequences of the ADD problematic behavior. (19)
14. Ask the client to make a “pros and cons” spreadsheet regarding staying on psychotropic medications; process the results.
15. Encourage and support the client in remaining on psychotropic medication and warmly but firmly confront thoughts of discontinuing when they surface (or assign “Why I Dislike Taking My Medication” in the *Adult Psychotherapy Homework Planner* by Jongsma).
16. Assist the client in identifying the current specific behaviors that cause him/her the most difficulty functioning as part of identifying treatment targets (i.e., a functional analysis).
17. Review the results of psychological testing and/or psychiatric evaluation again with the client assisting in identifying or in affirming his/her choice of the most problematic behavior(s) to address.
18. Ask the client to have extended family members and close collaterals complete a ranking of the behaviors they see as interfering the most with his/her daily functioning (e.g., mood swings, temper outbursts, easily stressed, short attention span, never completes projects).
19. Assign the client to make a list of negative consequences that he/she has experienced or that could result from a continuation of the problematic behavior; process the list (or assign “Impulsive Behavior Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma).

- ▼^{EB} 11. Invite a significant other to join in the therapy to provide support throughout therapy. (20, 21)
- ▼^{EB} 12. Increase knowledge of ADHD and its treatment. (22, 23, 24)
13. Read self-help books about ADHD to improve
20. Direct the client to invite a significant other to participate in the therapy; train the significant other throughout therapy to help support the change and reduce friction in the relationship introduced by the ADHD. ▼^{EB}
21. Instruct the client's significant other in the HOPE technique (i.e., Help, Obligations, Plans, and Encouragement) to help support the client's positive changes (see *Driven to Distraction* by Hallowell and Ratey). ▼^{EB}
22. Educate the client about the signs and symptoms of ADHD and how they disrupt functioning through the influence of distractibility, poor planning and organization, maladaptive thinking, frustration, impulsivity, and possible procrastination. ▼^{EB}
23. Discuss a rationale for treatment where the focus will be improvement in organizational and planning skills, management of distractibility, cognitive restructuring, and overcoming procrastination (see *Mastering Your Adult ADHD: Therapist Manual* by Safren et al.). ▼^{EB}
24. Assign the client readings consistent with the treatment model to increase their knowledge of ADHD and its treatment (e.g., *Mastering Your Adult ADHD: Client Workbook* by Safren et al; *The Attention Deficit Disorder in Adults Workbook* by Weis). ▼^{EB}
25. Assign the client self-help readings that help facilitate the

understanding of the condition and its features. (25)

client's understanding of ADHD (e.g., *Driven to Distraction* by Hallowell and Ratey; *ADHD: Attention-Deficit Hyperactivity Disorder in Children, Adolescents, and Adults* by Wender; *Putting on the Brakes* by Quinn and Stern; *You Mean I'm Not Lazy, Stupid or Crazy?* by Kelly and Ramundo); process the material read.

▼ 14. Learn and implement organization and planning skills. (26, 27, 28, 29)

26. Teach the client organization and planning skills including the routine use of a calendar and daily task list. ▼

27. Develop with the client a procedure for classifying and managing mail and other papers. ▼

28. Teach the client problem-solving skills (i.e., identify problem, brainstorm all possible options, evaluate the pros and cons of each option, select best option, implement a course of action, and evaluate results) as an approach to planning; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility. ▼

29. Assign homework (e.g., "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma) asking the client to apply problem-solving skills to an everyday problem (i.e., impulse control, anger outbursts, mood swings, staying on task, attentiveness); review and provide corrective feedback toward improving the skill. ▼

- ▼^{EB} 15. Learn and implement skills to reduce the disruptive influence of distractibility. (30, 31, 32, 33)
30. Assess the client's typical attention span by having them do a few "boring" tasks (e.g., sorting bills, reading something uninteresting) to the point that they report distraction; use this as an approximate measure of their typical attention span. ▼^{EB}
31. Teach the client stimulus control techniques that use external structure (e.g., lists, reminders, files, daily rituals) to improve on-task behavior; remove distracting stimuli in the environment; encourage the client to reward himself/herself for successful focus and follow-through. ▼^{EB}
32. Teach the client to break down tasks into meaningful smaller units that can be completed without being distracted based on their demonstrated attention span. ▼^{EB}
33. Teach the client to use timers or other cues to remind him/her to stop tasks before he/she gets distracted in an effort to reduce the time they may be distracted and off-task (see *Mastering Your Adult ADHD: Therapist Guide* by Safren et al.). ▼^{EB}
- ▼^{EB} 16. Identify, challenge, and change self-talk that contributes to maladaptive feelings and actions. (34, 35)
34. Use cognitive therapy techniques to help client identify maladaptive self-talk (e.g., "I must do this perfectly," "I can do this later," "I can't organize all these things"); challenge biases, and generate alternatives. ▼^{EB}
35. Assign homework asking client to implement cognitive restructuring skills while doing tasks in which maladaptive

- thinking has occurred previously; review and provide corrective feedback toward improving the skills. ▾
- ▾ 17. Acknowledge procrastination and the need to reduce it. (36)
- ▾ 18. Learn and implement skills to reduce procrastination. (37, 38, 39)
- ▾ 19. Combine skills learned in therapy into a new daily approach to managing ADHD. (40, 41, 42)
36. Assist the client in identifying positives and negatives of procrastinating toward the goal of engaging him/her in staying focused. ▾
37. Teach the client to apply new problem-solving skills to planning as a first step in overcoming procrastination; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility. ▾
38. Teach the client to apply new cognitive restructuring skills to challenge thoughts that encourage the use of procrastination (e.g., “I can do this later” or “I’ll finish this after I watch my TV show”) and embrace thoughts encouraging action. ▾
39. Assign homework asking the client to accomplish identified tasks without procrastination using the techniques learned in therapy; review and provide corrective feedback toward improving the skill and decreasing procrastination. ▾
40. Teach the client meditational and self-control strategies (e.g., “stop, look, listen, and think”) to delay the need for instant gratification and inhibit impulses to achieve more meaningful, longer-term goals. ▾
41. Select situations in which the client will be increasingly

- challenged to apply his/her new strategies for managing ADHD, starting with situations highly likely to be successful. ^{EB}▽
42. Use any of several techniques, including imagery, behavioral rehearsal, modeling, role-playing, or in vivo exposure/behavioral experiments to help the client consolidate the use of his/her new ADHD management skills. ^{EB}▽
- ^{EB}▽ 20. Implement relaxation procedures to reduce tension and physical restlessness. (43)
43. Instruct the client in various relaxation techniques (e.g., deep breathing, meditation, guided imagery) and encourage him/her to use them daily or when stress increases (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay). ^{EB}▽
21. Cooperate with brainwave biofeedback (neurotherapy) to improve impulse control and reduce distractibility. (44, 45)
44. Conduct, refer for, or administer EEG biofeedback (neurotherapy) to improve attention span, impulse control, and mood regulation.
22. List coping skills that will be used to manage ADD symptoms. (46)
45. Encourage the client to transfer the biofeedback training skills of relaxation and cognitive focusing to everyday situations (e.g., home, work, social).
23. Attend an ADD support group with or without significant other. (47)
46. Review with the client the symptoms that have been problematic and the newly learned coping skills he/she will use to manage the symptoms (or assign “Symptoms and Fixes for ADD” in the *Adult Psychotherapy Homework Planner* by Jongsma).
47. Refer the client to a specific group therapy for adults with ADD to increase the client’s

understanding of ADD, to boost his/her self-esteem, and to obtain feedback from others; encourage inclusion of significant other.

24. Report improved listening skills without defensiveness. (48)

48. Use role-playing and modeling to teach the client how to listen and accept feedback from others regarding his/her behavior.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:


Axis I:	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	296.xx	Bipolar I Disorder
	301.13	Cyclothymic Disorder
	296.90	Mood Disorder NOS
	312.30	Impulse-Control Disorder NOS
	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	304.30	Cannabis Dependence
	305.20	Cannabis Abuse

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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
314.00	F90.0	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
314.01	F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder
314.01	F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder
296.xx	F31.xx	Bipolar I Disorder
301.13	F34.0	Cyclothymic Disorder
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and DSM-5 Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

BIPOLAR DISORDER—DEPRESSION

BEHAVIORAL DEFINITIONS

1. Depressed or irritable mood.
2. Decrease or loss of appetite.
3. Diminished interest in or enjoyment of activities.
4. Psychomotor agitation or retardation.
5. Sleeplessness or hypersomnia.
6. Lack of energy.
7. Poor concentration and indecisiveness.
8. Social withdrawal.
9. Suicidal thoughts and/or gestures.
10. Feelings of hopelessness, worthlessness, or inappropriate guilt.
11. Low self-esteem.
12. Unresolved grief issues.
13. Mood-related hallucinations or delusions.
14. History of chronic or recurrent depression for which the client has taken antidepressant medication, been hospitalized, had outpatient treatment, or had a course of electroconvulsive therapy.
15. History of at least one hypomanic, manic, or mixed mood episode.

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LONG-TERM GOALS

1. Alleviate depressive symptoms and return to previous level of effective functioning.

2. Develop healthy thinking patterns and beliefs about self, others, and the world that lead to the alleviation and help prevent the relapse of depression.
3. Develop healthy interpersonal relationships that lead to the alleviation and help prevent the relapse of depression.
4. Appropriately grieve the loss in order to normalize mood and to return to previously adaptive level of functioning.
5. Normalize energy level and return to usual activities, good judgment, stable mood, more realistic expectations, and goal-directed behavior.
6. Achieve controlled behavior, moderated mood, more deliberative speech and thought process, and a stable daily activity pattern.
7. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation and help prevent the relapse of mood episodes.
8. Talk about underlying feelings of low self-esteem or guilt and fears of rejection, dependency, and abandonment.

SHORT-TERM OBJECTIVES

1. Describe mood state, energy level, amount of control over thoughts, and sleeping pattern. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings; express empathy and build rapport while assessing primary cognitive, behavioral, interpersonal, or other symptoms of the mood disorder.
2. Assess presence, severity, and impact of past and present mood episodes on social, occupational, and interpersonal functioning; supplement with semi-structured inventory, if desired (e.g., *Montgomery-Asberg Depression Rating Scale, Inventory to Diagnose Depression*).

2. Complete psychological testing to assess the nature and impact of mood problems. (3)
3. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar depression. (4)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
3. Arrange for the administration of an objective instrument(s) for evaluating relevant features of the bipolar disorder such as symptoms, communication patterns with family/significant others, expressed emotion (e.g., *Beck Depression Inventory–II* and/or *Beck Hopelessness Scale*; *Perceived Criticism Measure*); evaluate results and process feedback with the client or client and family; readminister as indicated to assess treatment response.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
5. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an

anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 9. Assess the client's history of suicidality and current state of suicide risk (see the Suicidal Ideation chapter in this *Planner* if suicide risk is present).
 10. Continuously assess and monitor the client's suicide risk.
 11. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her own basic needs, or symptom severity warrants it.
 12. Arrange for an evaluation with a psychiatrist to determine
5. Verbalize any history of past and present suicidal thoughts and actions. (9)
 6. State no longer having thoughts of self-harm. (10, 11)
 7. Cooperate with a medical/psychiatric evaluation for



medication needs to stabilize symptoms. (12)

appropriate pharmacotherapy (e.g., lithium carbonate, Depakote, Lamictal). ▽

- ▽ 8. Take prescribed medications as directed. (13, 14)
- ▽ 9. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (15)
- ▽ 10. Verbalize an understanding of the causes for, symptoms of, and treatment of mixed and/or depressive bipolar episodes. (16, 17)
- ▽ 11. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (18, 19)
13. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness. ▽
14. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in psychotherapy. ▽
15. Provide psychoeducation to the client and family using all modalities necessary, including reviewing the signs, symptoms, and phasic relapsing nature of the client's mood episodes; destigmatize and normalize. ▽
16. Teach the client a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to stresses that are manageable and the need for medication compliance. ▽
17. Provide the client with a rationale for treatment involving ongoing medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse. ▽
18. Educate the client about the importance of medication compliance; teach him/her the risk for relapse when medication is discontinued and work toward a commitment to prescription adherence. ▽

19. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance; develop a plan for recognizing and addressing them (see "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
- ▽^{EB} 12. Attend group psychoeducational sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (20, 21)
20. Conduct or refer the client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in development of bipolar disorder, its biological and psychological treatment (see the *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta).^{EB}▽
21. Teach the group members illness management skills (e.g., early warning signs, common triggers, coping strategies), problem-solving focused on life goals, and a personal care plan that emphasizes a regular sleep routine, the need to comply with medication, and ways to minimize relapse through stress regulation.^{EB}▽
- ▽^{EB} 13. Client and family members verbalize an understanding of bipolar disorder, factors that influence it, the role of medication and therapy. (22)
22. Conduct Family-Focused Treatment with the client and significant others beginning with psychoeducation emphasizing the biological nature of bipolar disorder, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, and early episode intervention (see *Bipolar*

Disorder by Miklowitz and Goldstein).[▽]

- ▽ 14. Family members implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (23, 24, 25, 26, 27)
23. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and risk for the client's relapse.[▽]
24. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills, including: offering positive feedback, active listening, making positive requests of others for behavior change, and giving constructive feedback in an honest and respectful manner while reducing negative expressed emotion.[▽]
25. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.[▽]
26. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills, including: defining the problem constructively and specifically; brainstorming solution options; evaluating options; choosing an option and implementing a plan; evaluating the results; and adjusting the plan.[▽]
27. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills; process results in

- session toward effective use; problem-solve obstacles; (see “Plan Before Acting” or “Problem-Solving: An Alternative to Impulsive Action” in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session. ▽^{EB}
- ▽^{EB} 15. Develop a “relapse drill” in which roles, responsibilities, and a course of action is agreed upon in the event that signs of relapse emerge. (28)
- ▽^{EB} 16. Identify and replace thoughts and behaviors that trigger manic or depressive symptoms. (29, 30, 31)
28. Help the client and family draw up a “relapse drill” detailing roles and responsibilities (e.g., who will call a meeting of the family to problem-solve potential relapse; who will call the client’s physician, schedule a serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan. ▽^{EB}
29. Use cognitive therapy techniques to explore and educate the client about cognitive biases that trigger his/her elevated or depressive mood (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.). ▽^{EB}
30. Assign the client a homework exercise in which he/she identifies self-talk reflective of mania, biases in the self-talk, alternatives (see “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. ▽^{EB}
31. Teach the client cognitive-behavioral coping and relapse prevention skills including delaying impulsive actions, structured scheduling of daily

activities, keeping a regular sleep routine, avoiding unrealistic goal striving, using relaxation procedures, identifying and avoiding episode triggers such as stimulant drug use, alcohol consumption, breaking sleep routine, or exposing self to high stress (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.).

- ▼ 17. Maintain a pattern of regular rhythm to daily activities. (32, 33, 34, 35)
- 32. Conduct Interpersonal and Social Rhythm Therapy beginning with the assessment of the client's daily activities using an interview and the Social Rhythm Metric (see *Treating Bipolar Disorder* by Frank).
- 33. Assist the client in establishing a more routine pattern of daily activities such as sleeping, eating, solitary and social activities, and exercise; use and review a form to schedule, assess, and modify these activities so that they occur in a predictable rhythm every day.
- 34. Teach the client about the importance of good sleep hygiene (see "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly (see the Sleep Disturbance chapter in this *Planner*).
- 35. Engage the client in a balanced schedule of "behavioral activation" by scheduling rewarding activities while not over-stimulating; (see "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework*

- ▼^{EB} 18. Discuss and resolve troubling personal and interpersonal issues. (36, 37, 38)
- ▼^{EB} 19. Participate in periodic “maintenance” sessions. (39)
20. Increase understanding of bipolar illness by reading a book on the disorder. (40)
- Planner* by Jongsma); use activity and mood monitoring to facilitate an optimal balance of activity; reinforce success. ▼^{EB}
36. Conduct the interpersonal component of Interpersonal and Social Rhythm Therapy beginning with the assessment the client’s current and past significant relationships; assess for themes related to grief, interpersonal role disputes, interpersonal role transitions, and interpersonal skills deficits (see *Treating Bipolar Disorder* by Frank). ▼^{EB}
37. Use interpersonal therapy techniques to explore and resolve issues surrounding grief, role disputes, role transitions, and social skills deficits; provide support and strategies for resolving identified interpersonal issues. ▼^{EB}
38. Establish a “rescue protocol” with the client and significant others to identify and manage clinical deterioration; include medication use, sleep pattern restoration, maintaining a daily routine and conflict-free social support. ▼^{EB}
39. Hold periodic “maintenance” sessions within the first few months after therapy to facilitate the client’s positive changes; problem-solve obstacles to improvement. ▼^{EB}
40. Ask the client to read a book on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder*

Survival Guide by Miklowitz; *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping with Symptoms, and More* by White and Preston); review and process concepts learned through the reading.

21. Differentiate between real and imagined losses, rejections, and abandonments. (41, 42, 43)
22. Verbalize grief, fear, and anger regarding real or imagined losses in life. (44, 45, 46)
23. Use mindfulness and acceptance strategies to reduce experiential and cognitive avoidance and increase value-based behavior. (47)
41. Pledge to be there consistently to help, listen to, and support the client.
42. Explore the client's fears of abandonment by sources of love and nurturance.
43. Help the client differentiate between real and imagined, actual and exaggerated losses.
44. Probe real or perceived losses in the client's life.
45. Review ways for the client to replace the losses and put them in perspective.
46. Probe the causes for the client's low self-esteem and abandonment fears in the family-of-origin history.
47. Conduct Acceptance and Commitment Therapy (see *ACT for Depression* by Zettle) including mindfulness strategies to help the client decrease experiential avoidance, disconnect thoughts from actions, accept one's experience rather than change or control symptoms, and behave according to his/her broader life values; assist the client in clarifying his/her goals and values and commit to behaving accordingly).

- 24. Increasingly verbalize hopeful and positive statements regarding self, others, and the future (48, 49)
- 48. Assign the client to write at least one positive affirmation statement daily regarding himself/herself and the future (see “Positive Self-Talk” in the *Adult Psychotherapy Homework Planner* by Jongsma).
- 49. Teach the client more about depression and how to recognize and accept some sadness as a normal variation in feeling.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	295.70	Schizoaffective Disorder
	296.80	Bipolar Disorder NOS
	310.1	Personality Change Due to Axis III Disorder
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	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F31.1x	Bipolar I Disorder, Manic
296.89	F31.81	Bipolar II Disorder
301.13	F34.0	Cyclothymic Disorder
295.70	F25.1	Schizoaffective Disorder, Depressive Type
296.80	F31.9	Unspecified Bipolar and Related Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition

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Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

BIPOLAR DISORDER—MANIA

BEHAVIORAL DEFINITIONS

1. Exhibits an abnormally and persistently elevated, expansive, or irritable mood with at least three symptoms of mania (i.e., inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, excessive goal-directed activity or psychomotor agitation, excessive involvement in pleasurable, high-risk behavior).
2. The elevated mood or irritability (mania) causes marked impairment in occupational functioning, social activities, or relationships with others.
3. Demonstrates loquaciousness or pressured speech.
4. Reports flight of ideas or thoughts racing.
5. Verbalizes grandiose ideas and/or persecutory beliefs.
6. Shows evidence of a decreased need for sleep.
7. Reports little or no appetite.
8. Exhibits increased motor activity or agitation.
9. Displays a poor attention span and is easily distracted.
10. Loss of normal inhibition leads to impulsive and excessive pleasure-oriented behavior without regard for painful consequences.
11. Engages in bizarre dress and grooming patterns.
12. Exhibits an expansive mood that can easily turn to impatience and irritable anger if goal-oriented behavior is blocked or confronted.
13. Lacks follow-through in projects, even though energy is very high, since behavior lacks discipline and goal-directedness.

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LONG-TERM GOALS

1. Alleviate manic/hypomanic mood and return to previous level of effective functioning.
2. Normalize energy level and return to usual activities, good judgment, stable mood, more realistic expectations, and goal-directed behavior.
3. Reduce agitation, impulsivity, and pressured speech while achieving sensitivity to the consequences of behavior and having more realistic expectations.
4. Achieve controlled behavior, moderated mood, more deliberative speech and thought process, and a stable daily activity pattern.
5. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation and help prevent the relapse of manic/hypomanic episodes.
6. Talk about underlying feelings of low self-esteem or guilt and fears of rejection, dependency, and abandonment.

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SHORT-TERM OBJECTIVES

1. Describe mood state, energy level, amount of control over thoughts, and sleeping pattern. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings; express empathy, and build rapport while assessing primary cognitive, behavioral, interpersonal, or other symptoms of the mood disorder.
2. Assess presence, severity, and impact of past and present mood episodes including mania (i.e., pressured speech, impulsive behavior, euphoric mood, flight of ideas, reduced need for sleep, inflated self-esteem, and high energy) on social, occupational, and interpersonal functioning;

- supplement with semi-structured inventory, if desired (e.g., *Young Mania Rating Scale*; the *Clinical Monitoring Form*); readminister as indicated to assess treatment response.
2. Complete psychological testing to assess the nature and impact of mood problems. (3)
 3. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar mania. (4)
 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
 3. Arrange for the administration of an objective instrument(s) for evaluating relevant features of the bipolar disorder such as communication patterns with family/significant others, particularly expressed emotion (e.g., *Perceived Criticism Measure*); evaluate the results and process feedback with the client or client and family.
 4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
 5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
 6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional

defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 9. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her own basic needs, or symptom severity warrants it.
 10. Arrange for a medication evaluation with a psychiatrist to determine appropriate pharmacotherapy (e.g., lithium carbonate, Depakote, Lamictal).
 11. Monitor the client for use and effectiveness of psychotropic
- ▼ 5. Cooperate with a medical/psychiatric evaluation for medication needs and possible hospitalization to stabilize symptoms. (9, 10)
- ▼ 6. Take prescribed medications as directed. (11, 12)

- medication (e.g., compliance, side effects, and effectiveness).^{EB}▽
- ▽^{EB} 7. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (13)
 - ▽^{EB} 8. Verbalize an understanding of the causes for, symptoms of, and treatment of manic, hypomanic, and/or mixed episodes. (14, 15, 16)
 - ▽^{EB} 9. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (17, 18)
 12. Continually evaluate the client's compliance with the psychotropic medication prescription.^{EB}▽
 13. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in individual or group psychotherapy.^{EB}▽
 14. Provide psychoeducation to the client and family, using all modalities necessary, including reviewing the signs, symptoms, and phasic relapsing nature of the client's manic mood episodes; destigmatize and normalize (see *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta).^{EB}▽
 15. Teach the client a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to stresses that are manageable and the need for medication compliance.^{EB}▽
 16. Provide the client with a rationale for treatment involving ongoing medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse.^{EB}▽
 17. Educate the client about the importance of medication compliance; teach him/her the risk for relapse when medication is discontinued, and work toward a commitment to prescription adherence.^{EB}▽

18. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance; develop a plan for recognizing and addressing them (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}
- ▽^{EB} 10. Attend group psychoeducational sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (19, 20)
19. Conduct or refer client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in development of BPD, its biological and psychological treatment (see *Structured Group Psychotherapy for Bipolar Disorder* by Bauer and McBride; *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta).^{EB}
20. Teach the group members illness management skills (e.g., early warning signs, common triggers, coping strategies), problem-solving focused on life goals, and a personal care plan that emphasizes a regular sleep routine, the need to comply with medication, and ways to minimize relapse through stress regulation.^{EB}
- ▽^{EB} 11. Identify and replace thoughts and behaviors that trigger manic or depressive symptoms. (21, 22, 23)
21. Use cognitive therapy techniques to explore and educate the client's about cognitive biases that trigger his/her elevated or depressive mood (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.).^{EB}
22. Assign the client a homework exercise in which he/she identifies self-talk reflective of mania, biases

in the self-talk, alternatives (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. ▽

12. Client and family members verbalize an understanding of bipolar disorder, factors that influence it, and the role of medication and therapy. (24, 25)
23. Teach the client cognitive behavioral coping and relapse prevention skills including delaying impulsive actions, structured scheduling of daily activities, keeping a regular sleep routine, avoiding unrealistic goal striving, using relaxation procedures, identifying and avoiding episode triggers such as stimulant drug use, alcohol consumption, breaking sleep routine, or exposing self to high stress (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.). ▽
24. Conduct Family-Focused Treatment with the client and significant others beginning with psychoeducation emphasizing the biological nature of bipolar disorder, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, and early episode intervention (see *Bipolar Disorder* by Miklowitz and Goldstein).
25. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and risk for the client’s relapse.

13. Family members implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (26, 27, 28, 29)
14. Develop a "relapse drill" in which roles, responsibilities, and a course of action is agreed upon
26. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills, including offering positive feedback, active listening, making positive requests of others for behavior change, and giving constructive feedback in an honest and respectful manner.
27. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.
28. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills, including defining the problem constructively and specifically, brainstorming solution options, evaluating the pros and cons of each option, choosing an option and implementing a plan, evaluating the results, and adjusting the plan.
29. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills (or assign "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session toward effective use; problem-solve obstacles.
30. Help the client and family draw up a "relapse drill" detailing roles and responsibilities

in the event that signs of relapse emerge. (30)

(e.g., who will call a meeting of the family to problem-solve potential relapse; who will call the client's physician, schedule a serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan.

15. Maintain a pattern of regular rhythm to daily activities. (31, 32, 33, 34)

31. Conduct Interpersonal and Social Rhythm Therapy beginning with the assessment of the client's daily activities using an interview and the Social Rhythm Metric (see *Treating Bipolar Disorder* by Frank).

32. Assist the client in establishing a more routine pattern of daily activities such as sleeping, eating, solitary and social activities, and exercise; use and review a form to schedule, assess, and modify these activities so that they occur in a predictable rhythm every day.

33. Teach the client about the importance of good sleep hygiene (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly (see the Sleep Disturbance chapter in this *Planner*).

34. Engage the client in a balanced schedule of "behavioral activation" by scheduling rewarding activities while not over-stimulating (see "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); use activity and mood monitoring

- to facilitate an optimal balance of activity; reinforce success.
16. Discuss and resolve troubling personal and interpersonal issues. (35, 36, 37)
 17. Participate in periodic “maintenance” sessions. (38)
 18. Increase understanding of bipolar illness by reading a book on the disorder. (39)
 35. Conduct the interpersonal component of Interpersonal and Social Rhythm Therapy beginning with the assessment of the client’s current and past significant relationships; assess for themes related to grief, interpersonal role disputes, interpersonal role transitions, and interpersonal skills deficits.
 36. Use interpersonal therapy techniques to explore and resolve issues surrounding grief, role disputes, role transitions, and social skills deficits; provide support and strategies for resolving identified interpersonal issues.
 37. Establish a “rescue protocol” with the client and significant others to identify and manage clinical deterioration; include medication use, sleep pattern restoration, maintaining a daily routine, and conflict-free social support.
 38. Hold periodic “maintenance” sessions within the first few months after therapy to facilitate the client’s positive changes; problem-solve obstacles to improvement.
 39. Ask the client to read a book on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder Survival Guide* by Miklowitz; *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping with Symptoms, and More* by White

- 19. Differentiate between real and imagined losses, rejections, and abandonments. (40, 41, 42)

- 20. Verbalize grief, fear, and anger regarding real or imagined losses in life. (43, 44)

- 21. Acknowledge the low self-esteem and fear of rejection that underlie the braggadocio. (45, 46)

and Preston); review and process concepts learned through the reading.

- 40. Pledge to be there consistently to help, listen to, and support the client.
- 41. Explore the client’s fears of abandonment by sources of love and nurturance.
- 42. Help the client differentiate between real and imagined, actual and exaggerated losses.
- 43. Probe real or perceived losses in the client’s life.
- 44. Review ways for the client to replace the losses and put them in perspective.
- 45. Probe the causes for the client’s low self-esteem and abandonment fears in the family-of-origin history.
- 46. Confront the client’s grandiosity and demandingness gradually but firmly; emphasize his/her good qualities (or assign “What Are My Good Qualities?” or “Acknowledging My Strengths” in the *Adult Psychotherapy Homework Planner* by Jongsma).

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DIAGNOSTIC SUGGESTIONS


Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	295.70	Schizoaffective Disorder
	296.80	Bipolar Disorder NOS
	310.1	Personality Change Due to Axis III Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F31.1x	Bipolar I Disorder, Manic
296.89	F31.81	Bipolar II Disorder
301.13	F34.0	Cyclothymic Disorder
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
296.80	F31.9	Unspecified Bipolar and Related Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

BORDERLINE PERSONALITY DISORDER

BEHAVIORAL DEFINITIONS

1. A minor stress leads to extreme emotional reactivity (anger, anxiety, or depression) that usually lasts from a few hours to a few days.
2. A pattern of intense, chaotic interpersonal relationships.
3. Marked identity disturbance.
4. Impulsive behaviors that are potentially self-damaging.
5. Recurrent suicidal gestures, threats, or self-mutilating behavior.
6. Chronic feelings of emptiness and boredom.
7. Frequent eruptions of intense, inappropriate anger.
8. Easily feels unfairly treated and believes that others can't be trusted.
9. Analyzes most issues in simple, dichotomous terms (e.g., right/wrong, black/white, trustworthy/deceitful) without regard for extenuating circumstances or complex situations.
10. Becomes very anxious with any hint of perceived abandonment in a relationship.
11. Transient stress-related paranoid ideation or dissociation symptoms.

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LONG-TERM GOALS

1. Develop and demonstrate coping skills to deal with mood swings.
2. Develop the ability to control impulsive behavior.
3. Replace dichotomous thinking with the ability to tolerate ambiguity and complexity in people and issues.

- 4. Develop and demonstrate anger management skills.
- 5. Learn and practice interpersonal relationship skills.
- 6. Terminate self-damaging behaviors (such as substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors).

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**SHORT-TERM
OBJECTIVES**

- 1. Discuss openly the history of cognitive, emotional, and behavioral difficulties that have led to seeking treatment. (1, 2, 3)

- 2. Disclose any history of substance use that may contribute to and complicate the treatment of borderline personality. (4)

**THERAPEUTIC
INTERVENTIONS**

- 1. Assess the client’s experiences of distress and disability, identifying behaviors (e.g., parasuicidal acts, angry outbursts, overattachment), affect (e.g., mood swings, emotional overreactions, painful emptiness), and cognitions (e.g., biases such as dichotomous thinking, overgeneralization, catastrophizing) that will become the targets of therapy.
- 2. Explore the client’s history of abuse and/or abandonment, particularly in childhood years.
- 3. Validate the client’s distress and difficulties as understandable given his/her particular circumstances, thoughts, and feelings.
- 4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as

well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

- ▽ 4. Verbalize an accurate and reasonable understanding of the process of therapy and what the therapeutic goals are. (9, 10)
- ▽ 5. Verbalize a decision to work collaboratively with the therapist toward the therapeutic goals. (11)
- 9. Orient the client to Dialectical Behavior Therapy (DBT), highlighting its multiple facets (e.g., support, collaboration, and coping/personal/interpersonal skills-building); its emphasis on exchange and negotiation, balancing the rational and emotional, and acceptance and change; as well as the dialectical/biosocial view of borderline personality, including constitutional and social influences (see *Cognitive-Behavioral Treatment of Borderline Personality Disorder* by Linehan). ▽
- 10. Throughout therapy, ask the client to read selected sections of books or manuals that reinforce therapeutic interventions (e.g., *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan). ▽
- 11. Solicit from the client an agreement to work collaboratively within the parameters of the DBT approach including staying in therapy for the specified time period, attending scheduled therapy sessions, working toward reducing suicidal behaviors, and participating in skills training to address the behaviors, emotions, and cognitions that have been identified as causing problems in his/her life. ▽

- ▽ 6. Verbalize any history of self-mutilation and suicidal urges and behavior. (12, 13, 14, 15)
- ▽ 7. Promise to initiate contact with the therapist or helpline if experiencing a strong urge to engage in self-harmful behavior. (16, 17)
- ▽ 8. Reduce actions that interfere with participating in therapy. (18)
12. Probe the nature and history of the client's self-mutilating behavior. ▽
13. Assess the client's suicidal gestures as to triggers, frequency, seriousness, secondary gain, and onset. ▽
14. Arrange for hospitalization, as necessary, when the client is judged to be harmful to self. ▽
15. Provide the client with an emergency helpline telephone number that is available 24 hours a day. ▽
16. Interpret the client's self-mutilation as an expression of the rage and helplessness that could not be expressed as a child victim of emotional abandonment or abuse; express the expectation that the client will control his/her response to the urge to self-mutilate. ▽
17. Elicit a promise (as part of a self-mutilation and suicide prevention contract) from the client that he/she will initiate contact with the therapist or a helpline if a suicidal urge becomes strong and before any self-injurious behavior occurs; throughout the therapy process, consistently assess the strength of the client's suicide potential. ▽
18. Continuously monitor, confront, and problem-solve client actions that threaten to interfere with the continuation of therapy such as missing appointments, noncompliance, and/or abruptly leaving therapy. ▽

- ▽^{EB} 9. Cooperate with an evaluation by a physician for psychotropic medication and take medication, if prescribed. (19, 20)
- ▽^{EB} 10. Reduce the frequency of maladaptive behaviors, thoughts, and feelings that interfere with attaining a reasonable quality of life. (21)
- ▽^{EB} 11. Participate in a group (preferably) or individual personal/interpersonal skills development course. (22, 23)
- 19. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate. ▽^{EB}
- 20. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning. ▽^{EB}
- 21. Use validation, dialectical strategies (e.g., metaphor, devil's advocate), and cognitive-behavioral strategies (e.g., cost-benefit analysis, cognitive restructuring, personal and interpersonal skills training) to help the client manage, reduce, or regulate maladaptive behaviors (e.g., angry outbursts, binge drinking, abusive relationships, high-risk sex, uncontrolled spending), thoughts (e.g., all-or-nothing thinking, catastrophizing, personalizing), and feelings (e.g., rage, hopelessness, abandonment); see *Cognitive-Behavioral Treatment of Borderline Personality Disorder* by Linehan). ▽^{EB}
- 22. Conduct group or individual skills training tailored to the client's identified problematic behavioral patterns with an emphasis on emotional regulation, distress tolerance, interpersonal effectiveness, and mindfulness. ▽^{EB}
- 23. Use behavioral strategies to teach identified skills (e.g., instruction, modeling, advising), strengthen them (e.g., role-playing, exposure exercises),

- and facilitate incorporation into the client's everyday life (e.g., homework assignments).^{EB}▽
- ▽^{EB} 12. Discuss previous or current posttraumatic stress. (24)
- ▽^{EB} 13. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (25, 26, 27)
24. After adaptive behavioral patterns and emotional regulation skills are evident, work with the client on remembering the facts of previous trauma, reducing avoidance or denial, increasing insight into its effects, reducing maladaptive emotional and/or behavioral responses to trauma-related stimuli, reducing self-blame, and increasing acceptance.^{EB}▽
25. Explore the client's schema and self-talk that mediates his/her trauma-related and other fears; identify and challenge biases; assist him/her in generating thoughts that correct for the negative biases, accept uncertainty, and build self-confidence.^{EB}▽
26. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery).^{EB}▽
27. Reinforce the client's positive, reality-based cognitive messages that reduce personal distress, enhance self-confidence, and increase adaptive action.^{EB}▽

- ▽^{EB} 14. Participate in imaginal and/or in vivo exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (28, 29, 30, 31)
- 28. Direct and assist the client in constructing a hierarchy of feared and avoided trauma-related stimuli. ▽^{EB}
- 29. Direct imaginal exposure to the trauma in session by having the client describe a chosen traumatic experience at an increasing, but client-chosen level of detail; integrate cognitive restructuring and repeat until associated anxiety reduces and stabilizes; record the session and have the client listen to it between sessions (see “Share the Painful Memory” in the *Adult Psychotherapy Homework Planner* by Jongsma and *Dialectical Behavior Therapy in Clinical Practice* by Linehan, Dimeff, and Koerner); review and reinforce progress, problem-solve obstacles. ▽^{EB}
- 30. Assign the client a homework exercise in which he/she does an exposure exercise and records responses or listens to a recording of an in-session exposure (see *Dialectical Behavior Therapy in Clinical Practice* by Linehan, Dimeff, and Koerner); review and reinforce progress; problem-solve obstacles. ▽^{EB}
- 31. For client with comorbid PTSD, conduct prolonged exposure therapy, cognitive processing therapy, or eye movement desensitization and reprocessing (see the PTSD chapter in this *Planner*). ▽^{EB}
- ▽^{EB} 15. Verbalize a sense of self-respect that is not dependent on others’ opinions. (32)
- 32. Help the client to clarify, value, believe, and trust in his/her evaluations of himself/herself,

others, and situations and to examine them nondefensively and independent of others' opinions in a manner that builds self-reliance but does not isolate the client from others. ▽

▽ 16. Engage in practices that help enhance a sustained sense of joy. (33)

33. Facilitate the client's personal and interpersonal growth and "capacity for sustained joy" by helping him/her choose experiences that strengthen self-awareness, personal values, and appreciation of life (e.g., engaging in value-consistent activities, spiritual practices, other relevant life experiences). ▽

▽ 17. Learn and apply problem-solving skills to conflicts in daily life. (34)

34. Teach the client problem-solving skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating the outcome, and readjusting the plan as necessary); use role-playing and modeling to apply this skill to daily life situations (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽

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DIAGNOSTIC SUGGESTIONS


Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	296.3x	Major Depressive Disorder, Recurrent
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Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

CHILDHOOD TRAUMA

BEHAVIORAL DEFINITIONS

1. Reports of childhood physical, sexual, and/or emotional abuse.
2. Description of parents as physically or emotionally neglectful as they were chemically dependent, too busy, absent, etc.
3. Description of childhood as chaotic as parent(s) was substance abuser (or mentally ill, antisocial, etc.), leading to frequent moves, multiple abusive spousal partners, frequent substitute caretakers, financial pressures, and/or many stepsiblings.
4. Reports of emotionally repressive parents who were rigid, perfectionist, threatening, demeaning, hypercritical, and/or overly religious.
5. Irrational fears, suppressed rage, low self-esteem, identity conflicts, depression, or anxious insecurity related to painful early life experiences.
6. Dissociation phenomenon (multiple personality, psychogenic fugue or amnesia, trance state, and/or depersonalization) as a maladaptive coping mechanism resulting from childhood emotional pain.

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LONG-TERM GOALS

1. Develop an awareness of how childhood issues have affected and continue to affect one's family life.
2. Resolve past childhood/family issues, leading to less anger and depression, greater self-esteem, security, and confidence.

3. Release the emotions associated with past childhood/family issues, resulting in less resentment and more serenity.
4. Let go of blame and begin to forgive others for pain caused in childhood.

SHORT-TERM OBJECTIVES

1. Describe what it was like to grow up in the home environment. (1, 2)
2. Acknowledge any dissociative phenomena that have resulted from childhood trauma. (3, 4)
3. State the role substance abuse has in dealing with emotional pain of childhood. (5)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Develop the client's family genogram and/or symptom line and help identify patterns of dysfunction within the family.
3. Assist the client in understanding the role of dissociation in protecting himself/herself from the pain of childhood abusive betrayals (see the Dissociation chapter in this *Planner*).
4. Assess the severity of the client's dissociation phenomena and hospitalize as necessary for his/her protection.
5. Assess the client's substance abuse behavior that has developed, in part, as a means of coping with feelings of childhood

- trauma. If alcohol or drug abuse is found to be a problem, encourage treatment focused on this issue (see the Substance Use chapter in this *Planner*).
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
 6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgement of the "problem described," is not concerned, and has no motivation to change).
 7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g.,

- the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Describe each family member and identify the role each played within the family. (10)
 6. Identify patterns of abuse, neglect, or abandonment within the family of origin, both current and historical, nuclear and extended. (11, 12)
 7. Identify feelings associated with major traumatic incidents in childhood and with parental child-rearing patterns. (13, 14, 15)
 10. Assist the client in clarifying his/her role within the family and his/her feelings connected to that role.
 11. Assign the client to ask parents about their family backgrounds and develop insight regarding patterns of behavior and causes for parents' dysfunction.
 12. Explore the client's painful childhood experiences (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 13. Support and encourage the client when he/she begins to express feelings of rage, sadness, fear, and rejection relating to family abuse or neglect.
 14. Assign the client to record feelings in a journal that describes memories, behavior, and emotions tied to his/her traumatic childhood experiences (or assign "How the Trauma Affects Me" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 15. Ask the client to read books on the emotional effects of neglect and abuse in childhood (e.g., *It*

Will Never Happen to Me by Black; *Outgrowing the Pain* by Gil; *Healing the Child Within* by Whitfield); process insights attained.

8. Identify how own parenting has been influenced by childhood experiences. (16)
9. Enroll in dialectical behavior therapy. (17)
10. Enroll in treatment for posttraumatic stress. (18)
11. Decrease feelings of shame by being able to verbally affirm self as not responsible for abuse. (19, 20, 21, 22)
16. Ask the client to compare his/her parenting behavior to that of parent figures of his/her childhood; encourage the client to be aware of how easily we repeat patterns that we grew up with.
17. For the client whose current distress and/or disability results from borderline personality disorder, provide or refer to dialectical behavior therapist (see the Borderline Personality Disorder chapter in this *Planner*).
18. For the client who is manifesting posttraumatic stress disorder, provide or refer to prolonged exposure therapy, cognitive processing therapy, or eye movement desensitization and reprocessing therapy (see the PTSD chapter in this *Planner*).
19. Assign writing a letter to mother, father, or other abuser in which the client expresses his/her feelings regarding the abuse.
20. Hold conjoint sessions where the client confronts the perpetrator of the abuse.
21. Guide the client in an empty chair exercise with a key figure connected to the abuse (i.e., perpetrator, sibling, or parent); reinforce the client for placing responsibility for the abuse or neglect on the caretaker.

12. Identify the positive aspects for self of being able to forgive all those involved with the abuse. (23, 24, 25)
13. Decrease statements of being a victim while increasing statements that reflect personal empowerment. (26, 27)
22. Consistently reiterate that responsibility for the abuse falls on the abusive adults, not the surviving child (for deserving the abuse), and reinforce statements that accurately reflect placing blame on perpetrators and on nonprotective, nonnurturant adults.
23. Assign the client to write a forgiveness letter to the perpetrator of abuse (or assign “Feelings and Forgiveness Letter” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the letter.
24. Teach the client the benefits (i.e., release of hurt and anger, putting issue in the past, opens door for trust of others, etc.) of beginning a process of forgiveness of (not necessarily forgetting or fraternizing with) abusive adults.
25. Recommend the client read books on the topic of forgiveness (e.g., *Forgive and Forget* by Smedes; *When Bad Things Happen to Good People* by Kushner).
26. Ask the client to complete an exercise that identifies the positives and negatives of being a victim and the positives and negatives of being a survivor; compare and process the lists.
27. Encourage and reinforce the client’s statements that reflect movement away from viewing self as a victim and toward personal empowerment as a survivor (or assign “Changing from Victim to Survivor” in the

Adult Psychotherapy Homework Planner by Jongsma).

14. Increase level of trust of others as shown by more socialization and greater intimacy tolerance. (28, 29)

28. Teach the client the share-check method of building trust in relationships (sharing a little information and checking as to the recipient's sensitivity in reacting to that information).

29. Teach the client the advantages of treating people as trustworthy given a reasonable amount of time to assess their character.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I: 300.4 Dysthymic Disorder
 296.xx Major Depressive Disorder
 300.3 Obsessive-Compulsive Disorder
 300.02 Generalized Anxiety Disorder
 309.81 Posttraumatic Stress Disorder
 300.14 Dissociative Identity Disorder
 995.53 Sexual Abuse of Child, Victim
 995.54 Physical Abuse of Child, Victim
 995.52 Neglect of Child, Victim

Axis II: 301.83 Borderline Personality Disorder
 301.7 Antisocial Personality Disorder
 301.6 Dependent Personality Disorder
 301.4 Obsessive-Compulsive Personality Disorder

Using *DSM-5/ICD-9-CM/ICD-10-CM*:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.3	F42	Obsessive-Compulsive Disorder
300.02	F41.1	Generalized Anxiety Disorder
309.81	F43.10	Posttraumatic Stress Disorder
300.14	F44.81	Dissociative Identity Disorder
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
995.52	T74.02XA	Child Neglect, Confirmed, Initial Encounter
995.52	T74.02XD	Child Neglect, Confirmed, Subsequent Encounter
301.7	F60.2	Antisocial Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.4	F60.5	Obsessive-Compulsive Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

CHRONIC PAIN

BEHAVIORAL DEFINITIONS

1. Experiences pain beyond the normal healing process (six months or more) that significantly limits physical activities.
2. Complains of generalized pain in many joints, muscles, and bones that debilitates normal functioning.
3. Uses increased amounts of medications with little, if any, pain relief.
4. Experiences tension, migraine, cluster, or chronic daily headaches of unknown origin.
5. Experiences back or neck pain, interstitial cystitis, or diabetic neuropathy.
6. Experiences intermittent pain such as that related to rheumatoid arthritis or irritable bowel syndrome.
7. Has decreased or stopped activities such as work, household chores, socializing, exercise, sex, or other pleasurable activities because of pain.
8. Experiences an increase in general physical discomfort (e.g., fatigue, night sweats, insomnia, muscle tension, body aches).
9. Exhibits signs and symptoms of depression.
10. Makes many complaintive, depressive statements like “I can’t do what I used to”; “No one understands me”; “Why me?”; “When will this go away?”; “I can’t take this pain anymore”; and “I can’t go on.”

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LONG-TERM GOALS

1. Acquire and utilize the necessary pain management skills.
2. Regulate pain in order to maximize daily functioning and return to productive employment.
3. Find relief from pain and build renewed contentment and joy in performing activities of everyday life.
4. Find an escape route from the pain.
5. Accept the chronic pain and move on with life as much as possible.
6. Lessen daily suffering from pain.

SHORT-TERM OBJECTIVES

1. Describe the nature of, history of, impact of, and understood causes of chronic pain. (1, 2)
2. Complete a thorough medical evaluation to rule out any alternative causes for the pain and reveal any new treatment possibilities. (3)
3. Disclose any history of substance use that may contribute to and

THERAPEUTIC INTERVENTIONS

1. Assess the manifestation of chronic pain, its history, current status, triggers, and methods of coping (see *The Handbook of Pain Assessment* by Turk and Melzack).
2. Assess the impact of the pain on the patient's functioning in everyday life, including changes in the client's mood, attitude, social, vocational, and familial/marital roles.
3. Refer the client to a physician or clinic to undergo a thorough medical evaluation to rule out any undiagnosed condition and to receive recommendations on any further treatment options.
4. Arrange for a substance abuse evaluation and refer the client

complicate the treatment of chronic pain. (4)

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

- moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Follow through on a referral to a pain management or rehabilitation program. (9, 10, 11)
 6. Complete a thorough medication review by a physician who is a specialist in dealing with chronic pain or headache conditions. (12)
 7. Participate in a cognitive-behavioral group therapy for pain management. (13)
 9. Give the client information on the options of pain management specialists or rehabilitation programs that are available and help him/her make a decision on which would be the best for him/her.
 10. Make a referral to a pain management specialist or clinic of the client's choice and have him/her sign appropriate releases for the therapist to have updates on progress from the program and to coordinate services.
 11. Elicit from the client a verbal commitment to cooperate with pain management specialists or rehabilitation program.
 12. Ask the client to complete a medication review with a specialist in chronic pain; confer with the physician afterward about his/her recommendations and process them with the client.
 13. Form a small, closed enrollment cognitive-behavioral treatment group (4–8 clients) pain management (see *Group Therapy for Patients with Chronic Pain* by Keefe et al.); supplement with *Managing*

Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook by Otis. ▾

- ▾ 8. Verbalize an understanding of pain. (14)
- ▾ 9. Verbalize an understanding of the rationale for treatment. (15, 16)
- ▾ 10. Identify and monitor specific pain triggers. (17)
14. Teach the client key concepts of rehabilitation versus biological healing, conservative versus aggressive medical interventions, acute versus chronic pain, benign versus nonbenign pain, cure versus management, appropriate use of medication, role of self-regulation techniques and other management techniques. ▾
15. Teach the client a rationale for treatment that helps him/her understand that thoughts, feelings, and behavior can affect pain; that there are coping techniques and skills that can be used to help them to adapt and respond to pain and the resultant problems; emphasize the role that the client can play in managing his/her own pain. ▾
16. Assign the client to read sections from books or treatment manuals that describe pain conditions and their cognitive-behavioral treatment (e.g., *The Chronic Pain Control Workbook* by Catalano and Hardin). ▾
17. Teach the client self-monitoring of his/her symptoms; ask the client to keep a pain journal that records time of day, where and what he/she was doing, the severity of stress at the time, the severity of, and what was done to alleviate the pain (or assign “Pain and Stress Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal with the client to increase understanding of the nature of

the pain, cognitive, affective, and behavioral triggers, and the positive or negative effects of the coping strategies he/she is currently using. ▽

- ▽ 11. Learn and implement calming skills such as relaxation, biofeedback, or mindfulness meditation to ease pain. (18, 19, 20, 21, 22)
18. Teach the client relaxation skills (e.g., progressive muscle relaxation, guided imagery, slow diaphragmatic breathing) or mindfulness meditation, explaining the rationale and how to apply these skills to his/her daily life (see *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens). ▽
19. Conduct or refer the client to biofeedback training (e.g., EMG for muscle tension-related pain); assign practice of the skill at home. ▽
20. Identify areas in the client's life where he/she can implement skills learned through relaxation or biofeedback. ▽
21. Assign a homework exercise in which the client implements somatic pain management skills and records the result; review and process during the treatment session. ▽
22. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Living Beyond Your Pain* by Dahl and Lundgren). ▽
- ▽ 12. Incorporate physical therapy into daily routine. (23)
23. Refer the client for physical therapy if pain is heterogeneous. ▽

- ▼^{EB} 13. Learn mental coping skills and implement with somatic skills for managing acute pain. (24)
- ▼^{EB} 14. Participate in Acceptance and Commitment Therapy for chronic pain. (25)
- ▼^{EB} 15. Increase the level and range of activity by identifying and engaging in values-consistent pleasurable activities. (26)
- ▼^{EB} 16. Incorporate physical exercise into daily routine. (27, 28)
24. Teach the client distraction techniques (e.g., pleasant imagery, counting techniques, alternative focal point) and how to use them with relaxation skills for the management of acute episodes of pain (or assign “Controlling the Focus on Physical Problems” in the *Adult Psychotherapy Homework Planner* by Jongsma).▼^{EB}
25. Conduct Acceptance and Commitment Therapy including mindfulness strategies to help the client: decrease avoidance, disconnect thoughts from actions, accept one’s experience rather than try to change or control symptoms, behave according to his/her broader life values, clarify his/her goals and values and commit to behaving accordingly (see *Acceptance and Commitment Therapy for Chronic Pain* by Dahl, Wilson, Luciano, and Hayes).▼^{EB}
26. Ask the client to create a list of activities that are pleasurable to him/her and/or consistent with identified goals and values; process the list, developing a plan of increasing the frequency of engaging in the selected activities.▼^{EB}
27. Assist the client in recognizing the benefits of regular exercise, encouraging him/her to implement exercise in daily life and monitor results (see *Exercising Your Way to Better Mental Health* by Leith); offer ongoing encouragement to stay with the regimen.▼^{EB}

- ▼ 17. Identify, challenge, and change maladaptive thoughts and beliefs about pain and pain management and replace them with more adaptive thoughts and beliefs. (29, 30, 31, 32, 33)
28. Refer the client to an athletic club to develop an individually tailored exercise or physical therapy program that is approved by his/her personal physician. ▼
29. Explore the client's schema and self-talk that mediate his/her pain response, challenging the biases, assisting him/her in generating thoughts that correct for the biases, facilitate coping, and build confidence in managing pain. ▼
30. Assign the client a homework exercise in which he/she identifies negative pain-related self-talk and positive alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. ▼
31. Use cognitive therapy techniques to help the client change his/her view of their pain and suffering from overwhelming to manageable. ▼
32. Use cognitive therapy techniques to help the client change his/her self-concept and role in pain management from passive, reactive, and helpless to active, resourceful, and competent. ▼
33. Assign the client to read about cognitive-behavioral approaches to pain management relevant books or treatment manuals (e.g., *Managing Chronic Pain: A Cognitive-behavioral Therapy Approach Workbook* by Otis;

The Pain Survival Guide by Turk and Winter; *The Chronic Pain Control Workbook* by Catalano and Hardin).^{VB}

- ^{VB} 18. Learn and implement specific coping skills as well as when and how to use them to manage pain and its consequences. (34)
- ^{VB} 19. Engage in positive self-talk as an alternative to the depressing, negative thoughts about self and the world. (35)
- ^{VB} 20. Integrate and implement all new mental, somatic, and behavioral ways of managing pain. (36)
- ^{VB} 21. Implement relapse prevention strategies for managing future challenges. (37, 38, 39)
34. Teach the client specific coping skills based on an assessment of need (e.g., problem-solving, social/communication, conflict resolution, goal-setting).^{VB}
35. Assist the client in reframing thoughts about his/her life as one that has many positive elements outside of the pain; ask him/her to list positive aspects of himself/herself as well as his life circumstances (or assign “Positive Self-Talk” and/or “What’s Good about Me and My Life?” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{VB}
36. Assist the client in integrating his/her pain management skills learned in therapy (e.g., calming, cognitive coping, distraction, activity scheduling, problem-solving); transition use from therapy sessions to daily life as mastery becomes evident; review, reinforcing success and problem-solving obstacles toward the goal of integration (see *Psychological Approaches to Pain Management* by Turk and Gatchel).^{VB}
37. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of pain or old habits (e.g., a “bad day”) and relapse with the persistent return of pain and previous cognitive and behavioral habits that exacerbate pain.^{VB}

- 22. Make changes in diet that will promote health and fitness. (40)
- 23. Investigate the use of alternative therapies to pain management. (41)
- 24. Connect with social network sources who support the therapeutic changes. (42)
- 38. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur, using the strategies learned during therapy. ^{EB}▽
- 39. Follow-up with the client periodically to problem-solve difficulties and reinforce successes. ^{EB}▽
- 40. Refer the client to a dietician for consultation around eating and nutritional patterns; process the results of the consultation, identifying changes he/she can make and how he/she might start implementing these changes.
- 41. Explore the client's openness to alternative therapies for pain management (e.g., acupuncture, hypnosis, therapeutic massage); refer for the services, if indicated.
- 42. Assess the client's social support network and encourage him/her to connect with those who facilitate or support the client's positive change.

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DIAGNOSTIC SUGGESTIONS


Using DSM-IV/ICD-9-CM:

Axis I:	307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
	307.80	Pain Disorder Associated With Psychological Factors
	300.81	Somatization Disorder
	300.11	Conversion Disorder
	296.3x	Major Depressive Disorder, Recurrent
	300.3	Obsessive-Compulsive Disorder
	302.70	Sexual Dysfunction NOS
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
307.89	F54	Psychological Factors Affecting Other Medical Conditions
307.80	F45.1	Somatic Symptom Disorder, With Predominant Pain
300.81	F45.1	Somatic Symptom Disorder
300.11	F44.x	Conversion Disorder
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
300.3	F42	Obsessive-Compulsive Disorder
302.70	F52.9	Unspecified Sexual Dysfunction
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

COGNITIVE DEFICITS¹

BEHAVIORAL DEFINITIONS

1. Client or client's family expresses concern about memory, concentration, "thinking," judgment, social behavior, or the ability to complete tasks.
2. Client receives negative feedback about school or work performance, when performance has typically been satisfactory.
3. Client makes frequent errors in everyday activities that were previously completed accurately.
4. Noticeable deterioration in everyday tasks such as keeping appointments, paying bills on time, recalling recent conversations, and processing mail.
5. Difficulty in recall of recent events.
6. Inappropriate or embarrassing social behavior, with history of effective social functioning.
7. Changes in driving safety not explained by visual problems.
8. Marked change in client's use of leisure time, with client reducing time spent on tasks requiring concentration (e.g., reading, woodworking, knitting, writing, puzzles, Internet searching).
9. Client reports higher levels of stress than usual when working on cognitively difficult tasks (e.g., organizing income tax information, making financial decisions, completing occupational tasks).

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¹ Content for this chapter was provided by Michele Rusin, coauthor with Arthur Jongsma of *The Rehabilitation Psychology Treatment Planner* (2001). Hoboken, NJ: Wiley.

LONG-TERM GOALS

1. Maintain effective functioning through the use of cognitive aids and strategies.
2. Adjust activities and responsibilities to level of cognitive capacity, cooperating with others who provide assistance or oversight.
3. Maintain physical and emotional health to maximize brain health and optimize cognitive performance.
4. Experience satisfaction in life while managing cognitive symptoms and resulting lifestyle changes.

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SHORT-TERM OBJECTIVES

1. Describe the history, nature, and severity of cognitive problems experienced. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Ask the client and (with authorization) the client’s family/support system, about the types and duration of the client’s cognitive problems, the temporal course (sudden, gradual, intermittent), and significant stressors occurring near the time of onset.
2. Ask the client and (with authorization) the client’s family/support system about the client’s use of prescribed and nonprescribed medications and substances (alcohol, street drugs, herbs).
3. Ask the client and (with authorization) the client’s family/support system, and/or physician(s) about the patient’s medical history, being attentive to conditions (e.g., hypothyroidism,

- diabetes, hypertension, strokes, etc.) that might impact cognitive functioning.
2. Participate in a brief psychometric assessment to quantify cognitive and emotional functioning, and to screen for alcohol abuse. (4, 5, 6)
 3. Give the therapist permission to speak with others about the types and durations of cognitive problems, while developing a treatment plan. (7)
 4. Cooperate with comprehensive evaluation procedures to assess
 4. Administer tests to quantify patterns of cognitive performance (e.g., *Repeatable Battery for the Assessment of Neuropsychological Status*) or to screen for demential cognitive impairment (e.g., *Mini Mental State Examination*; *Dementia Rating Scale-2*; *Memory Impairment Screen*), being attentive to the impact of age, educational level, and cultural background on the interpretation of scores.
 5. Ask the client to complete inventories to assess depression (e.g., *Beck Depression Inventory-II*; *Geriatric Depression Scale*), anxiety (e.g., *Beck Anxiety Inventory*; *State-Trait Anxiety Inventory*), posttraumatic stress disorder (e.g., *Detailed Assessment of Posttraumatic Stress*), or general emotional status (*Symptom Checklist 90-R*; *Brief Symptom Inventory-18*).
 6. Administer tests to screen for alcohol abuse (e.g., *CAGE* or *AUDIT*).
 7. With the client's authorization, talk with the client and family about initial impressions, and consult with the client's physician regarding symptoms, history, assessment results, and agree on a plan of care for the cognitive problem.
 8. Initiate or support referral to health care professionals skilled

cognition and factors impacting cognitive problems. (8)

in providing an in-depth assessment of cognitive disorders (e.g., neurologist, rehabilitation medicine physician, neuropsychologist, rehabilitation psychologist).^{▽▽}

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (9, 10, 11, 12)
9. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
11. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
12. Assess for the severity of the level of impairment to the client's functioning to determine

appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

- ▼ 6. Client and/or family describe their understanding of the assessment results and recommendations. (13, 14)
- 7. Agree to treatment of emotional disorders and/or substance dependence/abuse that may impact cognitive functioning. (15)
- ▼ 8. Consistently use written records and/or alarms to remind self of commitments and planned activities. (16, 17)
- 13. Discuss evaluation results with the client and family members; provide them with education as the nature of the deficits found and treatment options. ▼
- 14. Assess the degree of the client's and family's realistic appraisal of the client's functioning by inquiring into their perception of the problem areas, the reason for the problems, and the typical clinical course; talk with the client and family about differences between their beliefs and what professionals are saying. ▼
- 15. Develop and implement a treatment plan for depression, anxiety, and/ or substance abuse that might depress the client's cognition (see the Unipolar Depression, Anxiety, or Substance Abuse chapters in this *Planner*).
- 16. To address all levels of memory problems, recommend use of written, visible external aids (e.g., day planners, memory books, calendars, dry erase boards) and/or alarms to cue the client to commitments and

- planned activities; teach the client to use these aids. ▾
- ▾ 9. Use computerized devices consistently to compensate for areas of cognitive weakness. (18, 19)
- ▾ 10. Use internal or covert cognitive strategies to increase effective task performance. (20, 21, 22, 23, 24)
17. Inquire about the client's use of written external memory aids, and reinforce consistent use. ▾
18. Assist the client with the selection of computerized external aids (e.g., GPS navigation systems, PDAs, smart phones) that match his/her preferences, budget, and ability to learn to use them; teach the client to use these aids. ▾
19. Inquire into the client's use of computerized devices and reinforce use. ▾
20. For clients having mild impairments, demonstrate the use of repetition and enriched imagery (e.g., learning a person's name by repeating the name of the person during a conversation, and then associating their name with a physical feature (e.g., "Amy" has dark eyebrows that are "aiming" toward her nose). ▾
21. For clients having mild impairments, demonstrate the use of clustering (e.g., organize grocery list items into groups: [4 fruits: bananas, blueberries, lemons, strawberries; 3 dairy items: butter, milk, yogurt; 2 bakery items: bagels, bread]; remember these 3 groups, and then items within them, rather than trying to remember 9 random items) thereby focusing attention, enriching images, decreasing the cognitive load, and facilitating retrieval of information. ▾
22. For clients having mild impairments, teach the peg word

rhyme (1 is a bun, 2 is a shoe, etc.; see *How to Strengthen Memory by a New Process* by Sambrook) and demonstrate how use of the peg word system coupled with exaggerated imagery, enhances recall of information (e.g., learn cell phone number by developing a mental picture based upon the rhyme. For example, 573-8821 becomes a huge bee hive (5) reaching to heaven (7), with a tree (3) forming a slide down from heaven. Next are two gates (8, 8) behind which are an ornate shoe (2) with a sticky bun (1) inside. ▾

- ▾ 11. Use a systematic approach to problem-solving. (25)
- 12. Link new recurring activities to existing recurring activities. (26)
- 13. Accept and implement environmental changes to enhance everyday performance. (27)
- 23. Recommend the client cue self silently (e.g., “Focus” “Stay on task”) to maintain concentration and facilitate persistence. ▾
- 24. Inquire into the client’s use of covert aids and reinforce use. ▾
- 25. Teach patient to use a systematic problem solving strategy (e.g., SOLVE: S = Situation specified; O = Options listed with pros and cons; L = Listen to others; V = Voice a choice, implement an option; E = evaluate the outcome) (see *Overcoming Grief and Loss After Brain Injury* by Niemeier and Karol). ▾
- 26. Suggest the client use a behavioral chaining strategy to add a new recurring activity to existing recurring activity (e.g., instruct client to review day planner at the end of each meal).
- 27. Discuss ways to modify the client’s environment (e.g., reduce clutter, reduce distractions, maintain consistent placement

- of regularly used items, label locations of commonly used objects, identify one purse/wallet that the client will consistently use) to enhance functioning.
- ▼ 14. Participate in cognitive rehabilitation sessions and perform homework exercises. (28)
 - ▼ 15. Challenge self to accomplish cognitively difficult tasks that have been identified as “safe” by health care professionals. (29)
 - ▼ 16. Implement actions to enhance physical health. (30)
 - 17. Problem-solve with therapist around problems affecting adherence to treatment plan. (31)
 - ▼ 18. Family members make adjustments to cope with the client’s cognitive deficits. (32)
 - 28. Refer the client for cognitive rehabilitation services to address deficits and learn coping skills. ▼
 - 29. Work with the client to identify cognitively challenging, but reasonable activities (e.g., reading, puzzles, Mahjong, keeping up with sports) to build into the day. ▼
 - 30. Talk with the client about the positive impact of a healthy lifestyle (e.g., aerobic exercise, healthy diet, adequate sleep) on maintaining and perhaps improving cognition; inquire into implementation of these behaviors. ▼
 - 31. Support and periodically reinforce the client’s implementation of recommendations (e.g., adherence with medications, behavioral recommendations, participation in cognitive rehabilitation, use of strategies and aids, environmental modifications); problem-solve any obstacles to consistent treatment plan compliance.
 - 32. Educate family members that the client’s cognitive changes are a family problem; talk about the most commonly encountered problems and ways to deal with them, work with family to identify coping resources, encourage caregivers to take

- breaks, and recommend participation in recreational, social, and spiritual activities. ▽
19. Client and family verbalize questions, anxiety, sadness, and other emotions triggered by this change in client's functioning. (33)
 20. Express hope for the ability to experience satisfaction, love, and pleasure while managing the cognitive deficit. (34)
 21. Participate in an evaluation of driving skills, accepting results and recommendations. (35, 36, 37, 38)
 33. Assist the client and family members in working through grief, anger, and other emotions associated with the change in the client's functioning and their expectations for the future.
 34. Work with the client and family to create reasonable expectations about the client's capacities and to bolster confidence in everyone's ability to have a satisfying life as they manage this problem.
 35. Talk with the client and family members about the potential impact of the cognitive deficit on the client's driving safety.
 36. Develop a plan with the client and family to informally assess the client's driving skills (e.g., have client navigate through empty parking lot, observing the client's ability to maintain appropriate speed, to keep vehicle within a lane, to pull car into a parking space, to observe posted signs).
 37. Refer the client for an evaluation of driving skills administered by a professional trained to assess the impact of cognitive disorders on driving-related capacities.
 38. Talk with the client and/or family about the state law governing responsibilities to report persons having medical conditions that affect driving skills; follow state laws and HIPAA in taking action (e.g., making a report directly to a

- state agency, discussing concerns about driving with the client's physician); suggest the client voluntarily surrender his/her license and promise to not drive.
22. Utilize public transportation, or accept transportation with family and friends. (39)
 23. Consider the advice of professionals and others in selecting "safe" activities in which to invest one's time. (40)
 24. Family and client implement restrictions in a way that preserves client's experience of choice, while reducing confrontation. (41)
 - ▼ 25. Family members respond with empathy to the client's experience and allow the client to manage responsibilities and problems that are within his/her capacity. (42)
 39. Assist the client in identifying alternate transportation resources (e.g., public transportation, handicapped-accessible public transportation, volunteer drivers, friends, extended family); if applicable, recommend supervision while the client learns to use these services.
 40. Work with the health care team and family to identify which activities are safe and what restrictions are necessary; provide counsel to the client regarding deciding which activities one is free to engage in, which may require supervision or partial restrictions, and which must be abandoned.
 41. When possible, offer safe options for daily activities (e.g., provide small amounts of spending money for client to carry in a wallet, provide credit card with a low spending limit, review checks written by the client prior to mailing them); create impediments to the client engaging in dangerous behavior (e.g., keeping the client's car keys, disconnecting the car battery), if necessary.
 42. Educate family members about the positive effect of empathic responding and emotional support; describe the negative impact on functioning if excessive instrumental support

is provided, or the client is being “over-helped.”[▼]

- 26. Seek out reputable sources of information, advice, and support related to the underlying disease/injury. (43)
- 27. In consultation with an attorney, complete legal documents regarding proxy decision making and other legal issues. (44)
- 28. Verbalize an understanding of the Americans with Disabilities Act and ways to request accommodations in academic, work, or community settings. (45)
- 29. Identify and apply for benefits triggered by disability. (46)
- 43. Refer the client and family to resources to enhance coping effectiveness through education, skills-building, and emotional support; suggest written materials, web-based resources (see the Bibliotherapy Suggestions in Appendix A), and community support groups.
- 44. Talk with the client and family about the impact of cognitive impairment on a person’s ability to make legally binding decisions (e.g., contracts, advance directives, power of attorney designations, will); refer the client/family to attorneys with expertise in these areas (e.g., elder law).
- 45. Talk with the client and family about the Americans with Disabilities Act and inform as to how this act allows the client to obtain accommodations at school, work, or in other settings.
- 46. Educate the client and family about potential financial support benefits (e.g., disability insurance benefits, Social Security Disability, activation of long-term care policy benefits) and how to apply for them.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	294.9	Cognitive Disorder, NOS
	294.10	Dementia of the Alzheimer's Type, Without Behavioral Disturbance
	294.11	Dementia of the Alzheimer's Type, With Behavioral Disturbance
	290.40	Vascular Dementia Uncomplicated
	290.41	Vascular Dementia With Delirium
	290.42	Vascular Dementia With Delusions
	290.43	Vascular Dementia With Depressed Mood
	294.1x	Dementia Due to (Axis III Disorder)
	_____	_____
Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____


Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
799.59	R41.9	Unspecified Neurocognitive Disorder
294.11	F02.81	Probable Major Neurocognitive Disorder Due to (specify disorder), With Behavioral Disturbance
294.10	F02.80	Probable Major Neurocognitive Disorder Due to (specify disorder), Without Behavioral Disturbance
331.9	G31.9	Possible Major Neurocognitive Disorder Due to (specify disorder)
331.83	G31.84	Mild Neurocognitive Disorder Due to (specify disorder)
290.40	F01.51	Probable Major Vascular Neurocognitive Disorder With Behavioral Disturbance
290.40	F01.50	Probable Major Vascular Neurocognitive Disorder Without Behavioral Disturbance
331.9	G31.9	Possible Major Vascular Neurocognitive Disorder
331.83	G31.84	Mild Vascular Neurocognitive Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition
294.8	F06.8	Other Specified Mental Disorder Due to Another Medical Condition

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294.10	F02.80	Major Neurocognitive Disorder Due to Another Medical Condition, Without Behavioral Disturbance
294.11	F02.81	Major Neurocognitive Disorder Due to Another Medical Condition, With Behavioral Disturbance
291.2	F10.27	Alcohol-Induced Major Neurocognitive Disorder, Nonamnesic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder
291.1	F10.26	Alcohol-Induced Major Neurocognitive Disorder, Amnesic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder
291.89	F10.288	Alcohol-Induced Mild Neurocognitive Disorder, With Moderate or Severe Use Disorder

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 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

DEPENDENCY

BEHAVIORAL DEFINITIONS

1. Resists becoming self-sufficient, consistently relying on parents to provide financial support, housing, or caregiving.
2. A history of many intimate relationships with little, if any, space between the ending of one and the start of the next.
3. Strong feelings of panic, fear, and helplessness when faced with being alone as a close relationship ends.
4. Feelings easily hurt by criticism and preoccupied with pleasing others.
5. Inability to make decisions or initiate actions without excessive reassurance from others.
6. Frequent preoccupation with fears of being abandoned.
7. All feelings of self-worth, happiness, and fulfillment derive from relationships.
8. Involvement in at least two relationships wherein he/she was physically abused but had difficulty leaving the relationship.
9. Avoids disagreeing with others for fear of being rejected.

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LONG-TERM GOALS

1. Develop confidence in capability of meeting own needs and of tolerating being alone.
2. Achieve a healthy balance between independence and dependence.

3. Decrease dependence on relationships while beginning to meet own needs, build confidence, and practice assertiveness.
4. Break away permanently from any abusive relationships.
5. Emancipate self from emotional and economic dependence on parents.
6. Embrace the recovery model's emphasis on accepting responsibility for treatment decisions as well as the expectation of being able to live, work, and participate fully in the community.

SHORT-TERM OBJECTIVES

1. Describe the style and pattern of emotional dependence in relationships. (1)
2. Verbalize an increased awareness of own dependency. (2, 3)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)

THERAPEUTIC INTERVENTIONS

1. Explore the client's history of emotional dependence extending from unmet childhood needs to current relationships.
2. Develop a family genogram to increase the client's awareness of family patterns of dependence in relationships and assess how he/she is repeating them in the present relationship.
3. Assign the client to read *Co-dependent No More* by Beattie or *Women Who Love Too Much* by Norwood; process key ideas.
4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the

“problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 6. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 7. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 8. Explore the client’s family of origin for experiences of emotional abandonment.
4. Verbalize insight into the automatic practice of striving to meet other people’s expectations. (8, 9, 10)

5. List positive things about self. (11, 12)
6. Identify and replace distorted automatic thoughts associated with assertiveness, being alone, or acting independently. (13, 14, 15, 16)
9. Assist the client in identifying the basis for his/her fear of disappointing others (or assign “Taking Steps Toward Independence” from the *Adult Psychotherapy Homework Planner* by Jongsma).
10. Read with the client the fable entitled “The Bridge” in *Friedman’s Fables* by Friedman; process the meaning of the fable.
11. Assist the client in developing a list of his/her positive attributes and accomplishments (or assign “Acknowledging My Strengths” from the *Adult Psychotherapy Homework Planner* by Jongsma).
12. Assign the client to institute a ritual of beginning each day with 5 to 10 minutes of solitude where the focus is personal affirmation.
13. Explore and clarify the client’s fears or other negative feelings associated with being more independent.
14. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic thoughts associated with assertiveness, being alone, or not meeting others’ needs.
15. Reinforce the client for developing and implementing positive, reality-based messages

- to replace the distorted, negative self-talk associated with independent behaviors (or assign “Replacing Fears With Positive Messages” from the *Adult Psychotherapy Homework Planner* by Jongsma).
7. Verbalize a decreased sensitivity to criticism. (17, 18, 19)
 8. Increase saying no to others’ requests. (20)
 9. Report incidents of verbally stating own opinion. (21, 22)
 16. Assign the client a homework exercise (e.g., “Journal and Replace Self-Defeating Thoughts” from the *Adult Psychotherapy Homework Planner* by Jongsma) in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments; review and reinforce success, providing corrective feedback toward improvement.
 17. Explore the client’s sensitivity to criticism and help him/her develop new ways of receiving, processing, and responding to it.
 18. Assign the client to read books on assertiveness (e.g., *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships* by Alberti and Emmons).
 19. Verbally reinforce the client for any and all signs of assertiveness and independence.
 20. Assign the client to say no without excessive explanation for a period of one week and process this with him/her.
 21. Train the client in assertiveness or refer him/her to a group that will facilitate and develop his/her assertiveness skills via lectures and assignments.

10. Identify own emotional and social needs and ways to fulfill them. (23, 24)
11. Report examples of receiving favors from others without feeling the necessity of reciprocating. (25)
12. Verbalize an increased sense of self-responsibility while decreasing sense of responsibility for others. (26, 27, 28)
22. Assign the client to speak his/her mind for one day, and process the results with him/her.
23. Ask the client to compile a list of his/her emotional and social needs and ways that these could possibly be met; process the list (or assign “Satisfying Unmet Emotional Needs” from the *Adult Psychotherapy Homework Planner* by Jongsma).
24. Ask the client to list ways that he/she could start taking care of himself/herself; then identify two to three that could be started now and elicit the client’s agreement to do so. Monitor for follow-through and feelings of change about self.
25. Assign the client to allow others to do favors for him/her and to receive without giving. Process progress and feelings related to this assignment.
26. Assist the client in identifying and implementing ways of increasing his/her level of independence and making own decisions in day-to-day life (or assign “Making Your Own Decisions” from the *Adult Psychotherapy Homework Planner* by Jongsma).
27. Assist the client in not accepting responsibility for others’ actions or feelings; recommend the client read *Taking Responsibility: Self-Reliance and the Accountable Life* by Branden.
28. Facilitate conjoint session with the client’s significant other with focus on exploring ways to

13. Verbalize an increased awareness of boundaries and when they are violated. (29, 30, 31)
14. Increase the frequency of verbally clarifying boundaries with others. (32)
15. Increase the frequency of making decisions within a reasonable time and with self-assurance. (33, 34, 35, 36)
29. Assign the client to keep a daily journal regarding boundaries for taking responsibility for self and others and when he/she is aware of boundaries being broken by self or others.
30. Assign the client to read the book *Boundaries: Where You End and I Begin* by Katherine and process key ideas.
31. Ask the client to read the chapter on setting boundaries and limits in the book *A Gift to Myself* by Whitfield and complete the accompanying survey on personal boundaries; process the key ideas and results of the survey.
32. Reinforce the client for implementing boundaries and limits for self.
33. Confront the client's tendency toward decision avoidance and encourage his/her efforts to implement proactive decision making.
34. Teach the client problem-resolution skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating outcome, and readjusting plan as necessary).
35. Use modeling and role-playing with the client to apply the problem-solving approach to his/her avoidance of decision-making (or assign "Applying

Problem-Solving to Interpersonal Conflict” from the *Adult Psychotherapy Homework Planner* by Jongsma); encourage implementation of action plan, reinforcing success and redirecting for failure.

16. Participate in marital and/or family therapy. (37)

36. Give positive verbal reinforcement for each timely thought-out decision that the client makes.

37. Conduct or refer to marital and/or family therapy toward the goal of altering entrenched dysfunctional marital and/or family system patterns that support the client’s dependency.

17. Attend an Al-Anon group. (38)

38. Refer the client to Al-Anon or another appropriate self-help group to reinforce efforts to break the dependency cycle with a chemically dependent partner.

18. Develop a plan to end the relationship with abusive partner, and implement the plan with therapist’s guidance. (39, 40, 41)

39. Assign the client to read *The Verbally Abusive Relationship* by Evans; process key ideas and insights.

40. Refer the client to a safe house that provides counseling services to abused women.

41. Refer the client to a domestic violence program and monitor and encourage his/her continued involvement in the program.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	995.81	Physical Abuse of Adult, Victim
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Axis II:	301.82	Avoidant Personality Disorder
	301.83	Borderline Personality Disorder
	301.6	Dependent Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
995.81	Z69.11	Encounter for Mental Health Services for Victim of Spouse or Partner Violence, Physical
301.82	F60.6	Avoidant Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.6	F60.7	Dependent Personality Disorder

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DISSOCIATION

BEHAVIORAL DEFINITIONS

1. The existence of two or more distinct personality states that recurrently take full control of one's behavior.
2. An episode of the sudden inability to remember important personal identification information that is more than just ordinary forgetfulness.
3. Persistent or recurrent experiences of depersonalization; feeling as if detached from or outside of one's mental processes or body during which reality testing remains intact.
4. Persistent or recurrent experiences of depersonalization; feeling as if one is automated or in a dream.
5. Depersonalization sufficiently severe and persistent as to cause marked distress in daily life.

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LONG-TERM GOALS

1. Integrate the various personalities.
2. Reduce the frequency and duration of dissociative episodes.
3. Resolve the emotional trauma that underlies the dissociative disturbance.
4. Reduce the level of daily distress caused by dissociative disturbances.
5. Regain full memory.

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SHORT-TERM OBJECTIVES

1. Identify each personality and have each one tell its story. (1, 2, 3)

2. Complete psychological testing designed to further understand the nature and extent of dissociative experiences and personality. (4)

3. Cooperate with a referral to a neurologist to rule out organic factors in amnesic episodes. (5)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.

2. Without undue encouragement or leading, probe and assess the existence of the various personalities that take control of the client.

3. Conduct a functional analysis of the variables associated with dissociative states and their resolution including thoughts, feelings, actions, interpersonal variables, consequences, and secondary gains.

4. Conduct or refer for psychological testing of dissociation (e.g., *The Dissociative Experiences Scale*) and/or abnormal and normal personality features and traits (e.g., MMPI-2).

5. Refer the client to a neurologist for evaluation of any organic cause for memory loss experiences.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

- this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Complete a psychotropic medication evaluation with a physician. (10)
 6. Take prescribed psychotropic medications responsibly at times ordered by the physician. (11)
 7. Participate in a therapy to address personal and interpersonal vulnerabilities to dissociation. (12)
 8. Identify the key issues that trigger a dissociative state. (13, 14, 15)
 10. Arrange for an evaluation of the client for a psychotropic medication prescription.
 11. Monitor and evaluate the client's psychotropic medication prescription for compliance, effectiveness, and side effects.
 12. In clients whose dissociation appears functionally related to a clinical syndrome (e.g., PTSD) or personality disorder (e.g., Borderline Personality Disorder), conduct or refer to evidence-based treatment of the disorder (e.g., cognitive processing therapy or dialectical behavior therapy, respectively).
 13. Explore the feelings and traumatic circumstances that trigger the client's dissociative state (see the Childhood Trauma and Sexual Abuse Victim chapters in this *Planner*).
 14. Explore the client's sources of emotional pain or trauma, and feelings of fear, inadequacy, rejection, or abuse (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma).
 15. Assist the client in accepting a connection between his/her dissociating and avoidance of facing emotional conflicts/issues and painful emotions (e.g., experiential avoidance).

9. Decrease the number and duration of personality changes. (16, 17)
10. Practice relaxation and deep breathing as means of reducing anxiety that serves as a trigger for dissociation. (18, 19, 20)
16. Facilitate integration of the client's personality by supporting and encouraging him/her to stay focused on reality rather than escaping through dissociation (or assign "Staying Focused on the Present Reality" from the *Adult Psychotherapy Homework Planner* by Jongsma).
17. Emphasize to the client the importance of a here-and-now focus on reality rather than a preoccupation with the traumas of the past and dissociative phenomena associated with that fixation. Reinforce instances of here-and-now behavior.
18. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing-induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation) as part of a tailored strategy for reducing chronic and acute physiological tension that triggers dissociation.
19. Role-play the use of relaxation and cognitive coping to visualized stress-provoking scenes, moving from low- to high-stress scenes. Assign the implementation of calming techniques in his/her daily life when facing these trigger situations; process the results, reinforcing success and problem-solving obstacles.
20. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation*

and Stress Reduction Workbook by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow).

11. Identify, challenge, and replace self-talk that produces negative emotional reactions with self-talk that facilitates a better regulation of emotions. (21, 22, 23)
12. Verbalize acceptance of brief episodes of dissociation as not being the basis for panic, but only as passing phenomena. (24, 25, 26, 27, 28)
21. Explore the client's self-talk that mediates his/her strong negative/painful feelings and actions (e.g., "I can't face this"); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more realistic and regulated response. Combine new self-talk with calming skills as part of developing coping skills to manage negative emotions.
22. Role-play the use of relaxation and cognitive coping to visualized emotion-provoking scenes, moving from low- to high-challenge scenes. Assign the implementation of calming techniques in his/her daily life when facing trigger situations; process the results, reinforcing success and problem-solving obstacles.
23. Assign the client a homework exercise in which he/she identifies biased self-talk and generates alternatives that help moderate emotional reactions; review while reinforcing success, providing corrective feedback toward improvement.
24. Teach the client to be calm and matter-of-fact in the face of brief dissociative phenomena so as to not accelerate anxiety symptoms, but to stay focused on reality.

25. Use an ACT approach to help the client experience and accept the presence of painful/troubling thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
26. Teach mindfulness meditation to help the client change his/her relationship with painful thoughts and/or feelings, building acceptance of them without undue reactivity (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
27. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.
28. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (e.g., *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems* by Follette and Pistorello).
13. Discuss the period preceding memory loss and the period after memory returns. (14, 29)
14. Explore the client's sources of emotional pain or trauma, and feelings of fear, inadequacy, rejection, or abuse (or assign "Describe the Trauma" from the *Adult Psychotherapy Homework Planner* by Jongsma).

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| <p>14. Utilize photos and other memorabilia to stimulate recall of personal history. (30, 31)</p> | <p>29. Arrange and facilitate a session with the client and significant others to assist him/her in regaining lost personal information.</p> |
| <p>— · _____
_____</p> | <p>30. Calmly reassure the client to be patient in seeking to regain lost memories.</p> |
| <p>— · _____
_____</p> | <p>31. Review pictures and other memorabilia to gently trigger the client's memory recall.</p> |
| <p>— · _____
_____</p> | <p>— · _____
_____</p> |

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	<p>303.90 300.14 300.12 300.6 300.15</p> <p>_____ _____</p>	<p>Alcohol Dependence Dissociative Identity Disorder Dissociative Amnesia Depersonalization Disorder Dissociative Disorder NOS</p> <p>_____ _____</p>
Axis II:	<p>799.9 V71.09</p> <p>_____ _____</p>	<p>Diagnosis Deferred No Diagnosis</p> <p>_____ _____</p>

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.9	Unspecified Dissociative Disorder
300.15	F44.89	Other Specified Dissociative Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EATING DISORDERS AND OBESITY

BEHAVIORAL DEFINITIONS

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight.
4. Undue influence of body weight or shape on self-evaluation.
5. Strong denial of the seriousness of the current low body weight.
6. In postmenarcheal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles).
7. Escalating fluid and electrolyte imbalance resulting from eating disorder.
8. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
9. Recurrent episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior).
10. Eating much more rapidly than normal.
11. Eating until feeling uncomfortably full.
12. Eating large amounts of food when not feeling physically hungry.
13. Eating alone because of feeling embarrassed by how much one is eating.
14. Feeling disgusted with oneself, depressed, or very guilty after eating too much.
15. An excess of body weight, relative to height, that is attributed to an abnormally high proportion of body fat (Body Mass Index of 30 or more).

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LONG-TERM GOALS

1. Restore normal eating patterns, healthy weight maintenance, and a realistic appraisal of body size.
2. Stabilize medical condition with balanced fluid and electrolytes, resuming patterns of food intake that will sustain life and gain weight to a normal level.
3. Terminate the pattern of binge eating and purging behavior with a return to eating normal amounts of nutritious foods.
4. Terminate overeating and implement lifestyle changes that lead to weight loss and improved health.
5. Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder.
6. Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of the eating disorder.
7. Develop coping strategies (e.g., feeling identification, problem-solving, assertiveness) to address emotional issues that could lead to relapse of the eating disorder.

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SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, and frequency of food consumed or hoarded. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the historical course of the disorder including the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food);

- perceived personal and interpersonal triggers and personal goals.
3. Compare the client's calorie consumption with an average adult rate of 1,900 (for women) to 2,500 (for men) calories per day to determine over- or undereating.
 4. Measure the client's weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image.
 5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis.
 6. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the *Eating Inventory*; *Stirling Eating Disorder Scales*; or *Eating Disorders Inventory-3*); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.
 7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees
2. Describe any regular use of unhealthy weight control behaviors. (5)
 3. Complete psychological tests designed to assess and track eating patterns and unhealthy weight-loss practices. (6)
 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with a complete medical evaluation. (11)
6. Cooperate with a nutritional evaluation. (12)
7. Cooperate with a dental exam. (13)
- ▼ 8. Cooperate with a psychotropic medication evaluation by a physician and, if indicated, take medications as prescribed. (14, 15)
- ▼ 9. Cooperate with admission to inpatient treatment, if indicated. (16)
- ▼ 10. Verbalize an accurate understanding of how eating disorders develop. (17)
11. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client's medical condition.
12. Refer the client to a nutritionist experienced in eating disorders for an assessment of nutritional rehabilitation; coordinate recommendations into the care plan.
13. Refer the client to a dentist for a dental exam to assess the possible damage to teeth from purging behaviors and/or poor nutrition.
14. Assess the client's need for psychotropic medications (e.g., SSRIs); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated. ▼
15. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects. ▼
16. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal). ▼
17. Teach the client a model of eating disorders development that includes concepts such as sociocultural pressures to be

thin, overvaluation of body shape and size in determining self-image, maladaptive eating habits (e.g., fasting, bingeing, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn; *The Eating Disorders Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders* by Costin).^{VB}

- ▽ 11. Verbalize an understanding of the rationale for and goals of treatment. (18, 19)
18. Discuss a rationale for treatment consistent with the model being used including how cognitive, behavioral, interpersonal, lifestyle, and/or nutritional factors can promote poor self-image, uncontrolled eating, and unhealthy compensatory actions, and how changing them they can build physical and mental health-promoting eating practices.^{VB}
19. Assign the client to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with the treatment model (e.g., *Overcoming Binge Eating* by Fairburn; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder-Workbook* by Apple and Agras; *The LEARN Program for Weight Management* by Brownell for weight loss).^{VB}

- ▼ 12. Keep a journal of food consumption. (20)
- ▼ 13. Establish regular eating patterns by eating at regular intervals and consuming optimal daily calories. (21, 22, 23)
- ▼ 14. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (24, 25)
- ▼ 15. Identify and develop a list of high-risk situations for unhealthy eating or weight loss practices. (26, 27)
- 20. Assign the client to self-monitor and record food intake (or assign “A Reality Journal: Food, Weight, Thoughts, and Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to reinforce and facilitate motivation to change. ▼
- 21. Establish an appropriate daily caloric intake for the client and assist him/her in meal planning. ▼
- 22. Establish healthy weight goals for the client per the Body Mass Index (BMI), the Metropolitan Height and Weight Tables, or some other recognized standard. ▼
- 23. Monitor the client’s weight (e.g., weekly) and give realistic feedback regarding body weight. ▼
- 24. Monitor the client’s fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance. ▼
- 25. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor eating patterns. ▼
- 26. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client’s uncontrolled eating and/or compensatory weight management behaviors. ▼
- 27. Direct and assist the client in construction of a hierarchy of

- high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors. ▼
- ▼ 16. Learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices. (28)
- ▼ 17. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (29)
- ▼ 18. Identify, challenge, and replace self-talk and beliefs that promote the anorexia or bulimia. (30, 31, 32)
28. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, problem-solving, conflict resolution (e.g., empathy, active listening, “I messages,” respectful communication, assertiveness without aggression, compromise), or other social/communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations. ▼
29. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real life implementation by the client, reinforcing success while providing corrective feedback toward improvement. ▼
30. Conduct Phase One of Cognitive Behavioral Therapy (see *Cognitive Behavior Therapy and Eating Disorders* by Fairburn) to help the client understand the adverse effects of bingeing and purging; assigning self-monitoring of weight and eating patterns and establishing a regular pattern of eating (use “A Reality Journal: Food, Weight,

Thoughts, and Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material. ▼

31. Conduct Phase Two of Cognitive Behavioral Therapy (CBT) to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that mediate feelings and actions leading to maladaptive eating and weight control practices (or assign “How Fears Control My Eating” from the *Adult Psychotherapy Homework Planner* by Jongsma). ▼
32. Conduct Phase Three of CBT to assist the client in developing a maintenance and relapse prevention plan including self-monitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting short-term goals to stay on track. ▼
- ▼ 19. To begin to resolve bulimic behavior, identify important people in the past and present, and describe the quality, good and poor, of those relationships. (33)
33. Conduct Interpersonal Therapy (see “Interpersonal Psychotherapy for Bulimia Nervosa” by Fairburn) beginning with the assessment of the client’s “interpersonal inventory” of important past and present relationships, highlighting themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transition conflict, unresolved grief, and/or interpersonal deficits). ▼

- ▼ 20. Verbalize a resolution of current interpersonal problems and a resulting termination of bulimia. (34, 35, 36, 37)
- ▼ 21. Parents and adolescent with anorexia agree to participate in all three phases of family-based treatment of anorexia. (38, 39, 40)
34. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss. ▼
35. For disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship. ▼
36. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role. ▼
37. For interpersonal deficits, help the client develop new interpersonal skills and relationships. ▼
38. Conduct Phase One (sessions 1–10) of Family-Based Treatment (see *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* by Lock et al.) by confirming with the family their intent to participate and strictly adhere to the treatment plan, taking a history of the eating disorder, clarifying that the parents will be in charge of weight restoration of the client, establishing healthy weight

goals, and asking the family to participate in the family meal in session; establish with the parents and a physician a minimum daily caloric intake for the client and focus them on meal planning; consult with a physician and/or nutritionist if fluids and electrolytes need monitoring due to poor nutritional habits. ▾

39. Conduct Phase Two of Family-Based Treatment (FBT) (sessions 11–16) by continuing to closely monitor weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved and portions consumed are nearing what is normally expected and weight gain is demonstrated. ▾
 40. Conduct Phase Three of FBT (sessions 17–20) by reviewing and reinforcing progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills. ▾
 41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic spiritual value. ▾
 42. Assign the client to read the LEARN manual (see *The LEARN Program for Weight Management* by Brownell) and then review the five aspects of the program (i.e., Lifestyle,
- ▾ 22. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41)
 - ▾ 23. Follow through on implementing the five aspects of the LEARN program to achieve weight loss. (42, 43)

Exercise, Attitudes, Relationships, and Nutrition), that will be emphasized over the next 12 weeks. ▾

- ▾ 24. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (44, 45)
- ▾ 25. Implement relapse prevention strategies for managing possible future anxiety symptoms. (46, 47, 48)
43. In weekly sessions, systematically work through the five aspects of the LEARN program manual (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition), applying each component to the client's life to establish new behavioral patterns designed to achieve weight loss. ▾
44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, bingeing, then purging). ▾
45. Identify with the client future situations or circumstances in which lapses could occur. ▾
46. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse. ▾
47. Develop a "maintenance plan" with the client that describes how the client plans to identify challenges, use knowledge and skills learned in therapy to manage them, and maintain positive changes gained in therapy. ▾
48. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and

adjust to life without the eating disorder. ▾

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| <p>26. Attend an eating disorder group. (49)</p> <p>— · _____</p> <p>_____</p> <p>— · _____</p> <p>_____</p> <p>— · _____</p> <p>_____</p> | <p>49. Refer the client to a support group for eating disorders.</p> <p>— · _____</p> <p>_____</p> <p>— · _____</p> <p>_____</p> <p>— · _____</p> <p>_____</p> |
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	<p>307.1 Anorexia Nervosa</p> <p>307.51 Bulimia Nervosa</p> <p>307.50 Eating Disorder NOS</p> <p>xxx.xx Binge Eating Disorder</p> <p>316 Psychological Symptoms Affecting Axis III Disorder (e.g., obesity)</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p>
Axis II:	<p>301.6 Dependent Personality Disorder</p> <p>799.9 Diagnosis Deferred</p> <p>V71.09 No Diagnosis</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p>

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
307.1	F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
278.00	E66.9	Overweight or Obesity
307.50	F50.9	Unspecified Feeding or Eating Disorder
307.59	F50.8	Other Specified Feeding or Eating Disorder
301.6	F60.7	Dependent Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EDUCATIONAL DEFICITS

BEHAVIORAL DEFINITIONS

1. Failure to complete requirements for high school diploma or GED certificate.
2. Possession of no marketable employment skills and need for vocational training.
3. Functional illiteracy.
4. History of difficulties, not involving behavior, in school or other learning situations.
5. Lack of confidence in ability to learn.
6. Anxiety in situations requiring learning new skills and information.

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LONG-TERM GOALS

1. Recognize the need for high school completion or GED certificate and enroll in the necessary courses to obtain it.
2. Seek out vocational training to obtain marketable employment skill.
3. Increase literacy skills.
4. Overcome anxiety associated with learning.
5. Establish the existence of a learning disability and begin the development of skills to overcome it.

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SHORT-TERM OBJECTIVES

1. Identify the factors that contributed to termination of education. (1, 2)

2. Verbally verify the need for a high school diploma or GED. (3, 4, 5, 6, 7)

THERAPEUTIC INTERVENTIONS

1. Explore the client’s attitude toward education and the family, peer, and/or school experiences that led to termination of education.
2. Gather an educational history from the client that includes family achievement history and difficulties he/she had with regard to specific subjects (e.g., reading, math).
3. Advise the client of his/her need for further education.
4. Use a motivational interviewing approach to help the client explore motivational obstacles and incentives for acting to reach educational goals.
5. Assist the client in listing the negative effects that the lack of a GED certificate or high school diploma has had on his/her life.
6. Support and direct the client toward obtaining further academic training.
7. Reinforce and encourage the client in pursuing educational and/or vocational training by pointing out the social, monetary, and self-esteem advantages (or assign “The Advantages of Education” from

- the *Adult Psychotherapy Homework Planner* by Jongsma).
3. Complete an assessment to identify style of learning and to establish or rule out a specific learning disability. (8)
 4. Complete a medical evaluation of health status. (9)
 5. Cooperate with a psychological assessment for symptoms of another mental disorder that may affect or have affected educational achievement. (10)
 6. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar depression. (11)
 7. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (12, 13, 14, 15)
 8. Administer testing or refer the client to an educational specialist to be tested for learning style, cognitive strengths, and to establish or rule out a learning disability.
 9. Refer to a physician for a medical evaluation to assess for medical conditions that could affect educational performance and/or motivation (e.g., low energy/motivation due to hypothyroidism).
 10. Conduct or refer the client for a psychological assessment of Attention Deficit Disorder (see the Attention Deficit Disorder (ADD)—Adult chapter in this *Planner*) or other mental disorder that could affect educational performance or motivation (e.g., depression, anxiety).
 11. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
 12. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance

regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

13. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 14. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 15. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 16. Refer the client for a medication evaluation to treat his/her ADD or other identified mental disorder that could be affecting educational performance or motivation (e.g., depression, anxiety).
8. Complete an evaluation for psychotropic medications. (16, 17, 18)

9. Implement the recommendations of evaluations. (19)
10. Identify the facts and feelings related to negative, critical education-related experiences endured from parents, teachers, or peers. (20, 21)
11. Verbalize decreased anxiety and negativity associated with learning situations. (22, 23, 24, 25)
17. Encourage the client to take the prescribed psychotropic medications, reporting as to their effectiveness and side effects.
18. Monitor the client's psychotropic medication prescription compliance, effectiveness, and side effects.
19. Encourage the client to implement the recommendations of the educational, psychological, and medical evaluations.
20. Ask the client to list the negative messages he/she has experienced in learning situations from teachers, parents, and peers, and to process this list with the therapist.
21. Facilitate the client's openness regarding shame or embarrassment surrounding lack of reading ability, educational achievement, or vocational skill.
22. Give encouragement and verbal affirmation to the client as he/she works to increase his/her educational level.
23. Teach the client relaxation skills (e.g., progressive muscle relaxation, imagery, diaphragmatic breathing, verbal cues for deep relaxation), how to discriminate better between relaxation and tension, as well as how to apply these skills to coping with his/her own fears and anxieties in learning situations (e.g., see *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay).
24. Assign the client homework each session in which he or she

- practices relaxation exercises daily for at least 15 minutes and applies the technique to learning situations; review the exercises, reinforcing success while providing corrective feedback toward improvement.
25. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow).
 26. Assist the client in identifying his/her realistic academic and vocational strengths (or assign “My Academic and Vocational Strengths” from the *Adult Psychotherapy Homework Planner* by Jongsma).
 27. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic thoughts associated with education and his/her ability to learn.
 28. Reinforce the client for developing and implementing positive, reality-based messages to replace the distorted, negative self-talk associated with
12. Identify own academic and vocational strengths. (26)
 13. Identify and replace negative thoughts regarding educational opportunities and ability level. (27, 28, 29)

education and his/her ability to learn (or assign “Replacing Fears with Positive Messages” from the *Adult Psychotherapy Homework Planner* by Jongsma).

14. Agree to pursue educational assistance to attain reading skills. (30, 31)
15. State commitment to obtain further academic or vocational training. (32)
16. Make the necessary contacts to investigate enrollment in high school, GED, or vocational classes. (33, 34)
17. Attend classes consistently to complete academic degree and/or vocational training course. (35)
29. Assign the client a homework exercise (e.g., “Journal and Replace Self-Defeating Thoughts” from the *Adult Psychotherapy Homework Planner* by Jongsma) in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments; review and reinforce success, providing corrective feedback toward improvement.
30. Assess the client’s reading deficits.
31. Refer the client to resources for learning to read; monitor, and encourage the client’s follow-through.
32. Elicit a commitment from the client to pursue further academic or vocational training.
33. Provide the client with information regarding community resources available for adult education, GED, high school completion, and vocational skill training.
34. Assign the client to make preliminary contact with vocational and/or educational training agencies and report back regarding the experience.
35. Monitor and support the client’s attendance at educational or vocational classes.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	V62.3	Academic Problem
	V62.2	Occupational Problem
	315.2	Disorder of Written Expression
	315.00	Reading Disorder
_____	_____	_____
_____	_____	_____
Axis II:	V62.89	Borderline Intellectual Functioning
	317	Mild Mental Retardation
_____	_____	_____
_____	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
V62.3	Z55.9	Academic or Educational Problem
V62.2	Z56.9	Other Problem Related to Employment
315.2	F81.2	Specific Learning Disorder With Impairment in Written Expression
315.00	F81.0	Specific Learning Disorder With Impairment in Reading
V62.89	R41.83	Borderline Intellectual Functioning
317	F70	Intellectual Disability, Mild
317	F71	Intellectual Disability, Moderate

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

FAMILY CONFLICT

BEHAVIORAL DEFINITIONS

1. Constant or frequent conflict with parents and/or siblings.
2. A family that is not a stable source of positive influence or support, since family members have little or no contact with each other.
3. Ongoing conflict with parents, which is characterized by parents fostering dependence leading to feelings that the parents are overly involved.
4. Maintains a residence with parents and has been unable to live independently for more than a brief period.
5. Long period of noncommunication with parents, and description of self as the “black sheep.”
6. Remarriage of two parties, both of whom bring children into the marriage from previous relationships.
7. Parents in conflict with each other over parenting methods and styles for their minor children.

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LONG-TERM GOALS

1. Parents increase their cooperation and mutual support in dealing with their children.
2. Begin the process of emancipating from parents in a healthy way by making arrangements for independent living.

3. Decrease the level of present conflict with parents while beginning to let go of or resolving past conflicts with them.
4. Achieve a reasonable level of family connectedness and harmony where members support, help, and are concerned for each other.
5. Become a reconstituted/blended family unit that is functional and whose members are bonded to each other.
6. Reach a level of reduced tension, increased satisfaction, and improved communication with family and/or other authority figures.

SHORT-TERM OBJECTIVES

1. Describe the conflicts and the causes of conflicts between self and parents. (1, 2)

2. Attend and participate in family therapy sessions where the emphasis is on reducing conflict. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Give verbal permission for the client to have and express own feelings, thoughts, and perspectives in order to foster a sense of autonomy from family.
2. Explore the nature of the client's family conflicts and their perceived causes.
3. Conduct family therapy sessions with the client and his/her parents to facilitate healthy communication (where the focus is on controlled, reciprocal, respectful communication of thoughts and feelings), conflict resolution, and the normalization of the emancipation process.
4. Educate family members that resistance to change in styles of relating to one another is usually high and that change takes concerted effort by all members.

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

4. Identify own as well as others' role in the family conflicts. (9, 10)
5. Family members demonstrate increased openness by sharing thoughts and feelings about family dynamics, roles, and expectations. (11, 12)
6. Identify the role that chemical dependence behavior plays in triggering family conflict. (13)
7. Verbally describe an understanding of the role played by family relationship stress in triggering substance abuse or relapse. (14, 15)
- this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
9. Confront the client when he/she is not taking responsibility for his/her role in the family conflict and reinforce the client for owning responsibility for his/her contribution to the conflict.
10. Ask the client to read material on resolving family conflict (e.g., *Making Peace with Your Parents* by Bloomfield and Felder); encourage and monitor the selection of concepts to begin using in conflict resolution.
11. Conduct a family session in which a process genogram is formed that is complete with members, patterns of interaction, rules, and secrets.
12. Facilitate each family member in expressing his/her concerns and expectations regarding becoming a more functional family unit.
13. Assess for the presence of chemical dependence in the client or family members; emphasize the need for chemical dependence treatment, if indicated, and arrange for such a focus (see the Substance Use chapter in this *Planner*).
14. Help the client to see the triggers for chemical dependence relapse in the family conflicts.
15. Ask the client to read material on the family aspects of chemical

- dependence (e.g., *It Will Never Happen to Me* by Black; *Bradshaw On the Family* by Bradshaw); process key family issues from the reading that are triggers for him/her.
8. Increase the number of positive family interactions by planning activities. (16, 17, 18)
 9. Parents report how both are involved in the home and parenting process. (19, 20)
 10. Identify ways in which the parental team can be strengthened. (21)
 16. Refer the family for an experiential weekend at a center for family education to build skills and confidence in working together (consider a physical confidence class with low or high ropes courses, etc.).
 17. Ask the parents to read material on positive parenting methods (e.g., *Raising Self-Reliant Children* by Glenn and Nelsen; *Between Parent and Child* by Ginott; *Between Parent and Teenager* by Ginott); process key concepts gathered from their reading.
 18. Assist the client in developing a list of positive family activities that promote harmony (e.g., bowling, fishing, playing table games, doing work projects). Schedule such activities into the family calendar.
 19. Elicit from the parents the role each takes in the parental team and his/her perspective on parenting.
 20. Read and process in a family therapy session the fable "Raising Cain" or "Cinderella" (see *Friedman's Fables* by Friedman).
 21. Assist the parents in identifying areas that need strengthening in their "parental team," then work with them to strengthen these areas (or assign "Learning to

- ▼ 11. Parents learn and implement effective parenting methods to reduce conflict between themselves and the children over parenting. (22, 23, 24, 25, 26)
- Parent as a Team” in the *Adult Psychotherapy Homework Planner* by Jongsma).
22. Ask the parents to read material consistent with a parent training approach to managing disruptive children’s behavior (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together: The Basics* by Forgatch and Patterson; *Parents and Adolescents Living Together: Family Problem Solving* by Patterson and Forgatch). ▼
23. Describe the Parent Management Training approach to teach the parents how behavioral interactions with the child can encourage or discourage positive or negative behavior by the child and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (see *Parent Management Training-Oregon Model* by Forgatch and Patterson). ▼
24. Teach the parents how to specifically define and identify problem behaviors, identify their own reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior (or assign “Using Reinforcement Principles in Parenting” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼
25. Assign the parents to implement key parenting practices

consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise and clearly established rewards), use of calm, clear direct instruction, time out, and other loss-of-privilege practices for sustained problem behavior (assign “A Structured Parenting Plan” in the *Adult Psychotherapy Homework Planner* by Jongsma).²⁵

26. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign “Clear Rules, Positive Reinforcement, Appropriate Consequences” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.²⁶
 27. Use modeling, role-playing, and behavioral rehearsal to teach the client anger control techniques that include stop, think, and act as well as cognitive problem-solving skills; role-play the application of the skills to multiple situations in the client’s life.²⁷
 28. Assign the client to implement the anger control and problem-solving techniques in his/her daily living (or assign “Applying Problem-Solving to Interpersonal Conflict” in the *Adult*
- ²⁵ 12. Older children and teens learn skills for managing anger and solving problems without conflict. (27, 28)

- Psychotherapy Homework Planner* by Jongsma); review these incidents; reinforce and provide corrective feedback toward the goal of sustained effective use. ▽
- ▽ 13. Report an increase in resolving conflicts with parents by talking calmly and assertively rather than aggressively and defensively. (29, 30)
14. Parents increase structure within the family. (31, 32)
15. Each family member represents pictorially and then describes his/her role in the family. (33, 34)
29. Use role-playing, role reversal, modeling, and behavioral rehearsal to help the client develop assertive ways to resolve conflict with parents (recommend *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships* by Alberti and Emmons). ▽
30. Assign the parents to read material on reducing sibling conflict (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin); process key concepts and encourage implementation of interventions with their children. ▽
31. Assist parents in developing rituals (e.g., dinner times, bedtime readings, weekly family activity times) that will provide structure and promote bonding.
32. Assist the parents in increasing structure within the family by setting times for eating meals together, limiting number of visitors, setting a lights-out time, establishing a phone call cutoff time, curfew time, “family meeting” time, and so on.
33. Conduct a family session in which all members bring self-produced drawings of themselves in relationship to the family; ask each to describe what they’ve brought and then have the picture placed in an album.

16. Family members report a desire for and vision of a new sense of connectedness. (35, 36, 37)
17. Identify factors that lead to dependence on the family and verbalize steps to overcome them. (38, 39)
18. Increase the level of independent functioning. (40, 41)
34. Ask the family to make a collage of pictures cut out from magazines depicting “family” through their eyes and/or ask them to design a coat of arms that will signify the blended unit.
35. In a family session, assign the family the task of planning and going on an outing or activity; in the following session, process the experience with the family, giving positive reinforcement where appropriate.
36. Conduct a session with all new family members in which a genogram is constructed, gathering the history of both families and that visually shows how the new family connection will be.
37. Assign the parents to read the book *Changing Families* by Fassler, Lash, and Ives at home with the family and report their impressions in family therapy sessions.
38. Ask the client to make a list of ways he/she is dependent on parents.
39. For each factor that promotes the client’s dependence on parents, develop a constructive plan to reduce that dependence (or assign “Taking Steps toward Independence” in the *Adult Psychotherapy Homework Planner* by Jongsma).
40. Confront the client’s emotional dependence and avoidance of economic responsibility that promotes continuing pattern of living with parents; develop a plan for the client’s healthy and

responsible emancipation from parents that is, if possible, complete with their blessing (e.g., finding and keeping a job, saving money, socializing with friends, finding own housing, etc.).

41. Probe the client’s fears surrounding emancipation; support the client’s strengths that can lead to independence (or assign “Acknowledging My Strengths” in the *Adult Psychotherapy Homework Planner* by Jongsma) and assist the client in identifying and replacing fearful thoughts with positive messages (or assign “Replacing Fears With Positive Messages” in the *Adult Psychotherapy Homework Planner* by Jongsma).

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	313.81	Oppositional Defiant Disorder
	312.8	Conduct Disorder
	312.9	Disruptive Behavior Disorder NOS
	300.4	Dysthymic Disorder
	300.00	Anxiety Disorder NOS
	312.34	Intermittent Explosive Disorder
	303.90	Alcohol Dependence
	304.20	Cocaine Dependence
	304.80	Polysubstance Dependence


V71.02	Child or Adolescent Antisocial Behavior
V61.20	Parent-Child Relational Problem
V61.10	Partner Relational Problem
V61.8	Sibling Relational Problem

Axis II:	301.7	Antisocial Personality Disorder
	301.6	Dependent Personality Disorder
	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
312.34	F63.81	Intermittent Explosive Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
V61.8	Z63.8	High Expressed Emotion Level Within Family

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

FEMALE SEXUAL DYSFUNCTION

BEHAVIORAL DEFINITIONS

1. Describes consistently very low or no pleasurable anticipation of or desire for sexual activity.
2. Strongly avoids and/or is repulsed by any and all sexual contact in spite of a relationship of mutual caring and respect.
3. Recurrently experiences a lack of the usual physiological response of sexual excitement and arousal (genital lubrication and swelling).
4. Reports a consistent lack of a subjective sense of enjoyment and pleasure during sexual activity.
5. Experiences a persistent delay in or absence of reaching orgasm after achieving arousal and in spite of sensitive sexual pleasuring by a caring partner.
6. Describes genital pain experienced before, during, or after sexual intercourse.
7. Reports consistent or recurring involuntary spasm of the vagina that prohibits penetration for sexual intercourse.

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LONG-TERM GOALS

1. Increase desire for and enjoyment of sexual activity.
2. Attain and maintain physiological excitement response during sexual intercourse.

3. Reach orgasm with a reasonable amount of time, intensity, and focus to sexual stimulation.
4. Eliminate pain and achieve a presence of subjective pleasure before, during, and after sexual intercourse.
5. Eliminate vaginal spasms that prohibit penile penetration during sexual intercourse and achieve a sense of relaxed enjoyment of coital pleasure.

SHORT-TERM OBJECTIVES

1. Provide a detailed sexual history that explores current problems and past experiences that have influenced sexual attitudes, feelings, and behavior. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Conduct a thorough biopsychosocial sexual history that examines the client’s current adult sexual functioning as well as childhood and adolescent sexual experiences, level and sources of sexual knowledge, typical sexual practices and their frequency, medical history, drug and alcohol use, and lifestyle factors.
2. Assess the client’s attitudes and fund of knowledge regarding sex, emotional responses to it, and self-talk that may be contributing to the dysfunction.
3. Explore the client’s family of origin for factors that may be contributing to elements of the dysfunction such as negative attitudes regarding sexuality, feelings of inhibition, low self-esteem, guilt, fear, or repulsion (or assign “Factors Influencing Negative Sexual Attitudes” in

the *Adult Psychotherapy Homework Planner* by Jongsma).

2. Discuss any feelings of and causes for depression. (4)
3. Participate in treatment of depressive feelings that may be causing sexual difficulties. (5)
4. Honestly report substance abuse and cooperate with recommendations by the therapist for addressing it. (6)
5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)
4. Assess the role of depression in possibly causing the client's sexual dysfunction and treat if depression appears causal (see the Unipolar Depression chapter in this *Planner*).
5. Refer the client for an antidepressant medication prescription to alleviate depression.
6. Explore the client's use or abuse of mood-altering substances and their effect on sexual functioning; refer for focused substance abuse counseling.
7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased

- suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 6. Honestly and openly discuss the quality of the relationship including conflicts, unfulfilled needs, and anger. (11)
 11. Assess the quality of the relationship including couple satisfaction, distress, attraction, communication, and sexual repertoire toward making a decision to focus treatment on sexual problems or more broadly on the relationship (or assign "Positive and Negative Contributions to the Relationship: Mine and Yours" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 7. Cooperate with a physician's complete medical evaluation; discuss results with therapist. (12)
 12. Refer the client to a physician for a complete medical evaluation to rule out any general medical or substance-related causes of the sexual dysfunction (e.g., vascular,

8. Cooperate with physician's recommendation for addressing a medical condition or medication that may be causing sexual problems. (13)
9. Verbalize an understanding of the role that physical disease or medication has on sexual dysfunction. (14)
- ▽EB 10. Participate in sex therapy with a partner or individually if the partner is not available. (15)
- ▽EB 11. Participate in couples/marital therapy as part of addressing sexual problems. (16)
- ▽EB 12. Demonstrate healthy acceptance and accurate knowledge of sexuality by freely learning and discussing accurate information regarding sexual functioning. (17, 18)
- endocrine, medications), including a gynecological exam and assessment of pelvic floor musculature, if indicated (e.g., for a sexual pain condition).
13. Encourage the client to follow her physician's recommendations regarding treatment of a diagnosed medical condition or use of medication that may be causing the sexual problem.
14. Discuss the contributory role that a diagnosed medical condition or medication use may be having on the client's sexual functioning.
15. Encourage couples sex therapy or treat individually if a partner is not available (see *Enhancing Sexuality—Therapist Guide* by Wincze). ▽EB
16. For hypoactive desire or if problem issues go beyond sexual dysfunction, conduct sex therapy in the context of couples therapy (see "Does Marital Therapy Enhance the Effectiveness of Treatment for Sexual Dysfunction?" by Zimmer and the Intimate Relationship Conflicts chapter in this *Planner*). ▽EB
17. Disinhibit and educate the couple by encouraging them to talk freely and respectfully regarding her sexual body parts, sexual thoughts, feelings, attitudes, and behaviors. ▽EB
18. Reinforce the client for talking freely, knowledgeably, and positively regarding her sexual thoughts, feelings, and behavior. ▽EB

- ▼^{EB} 13. State a willingness to explore new ways to approach sexual relations. (19, 20)
- ▼^{EB} 14. List conditions and factors that positively affect sexual arousal such as setting, time of day, atmosphere. (21)
- ▼^{EB} 15. Identify and replace negative cognitive messages that trigger negative emotional reactions during sexual activity. (22, 23, 24)
19. Direct conjoint sessions with the client and her partner that focus on conflict resolution, expression of feelings, and sex education. ▼^{EB}
20. Assign books (e.g., *Sexual Awareness: Your Guide to Healthy Couple Sexuality* by McCarthy and McCarthy; *The Gift of Sex* by Penner and Penner; *For Each Other: Sharing Sexual Intimacy* by Barbach) that provide the client with accurate sexual information and/or outline sexual exercises that disinhibit and reinforce sexual sensate focus. ▼^{EB}
21. Assign the couple to list conditions and factors that positively affect their sexual arousal; process the list toward creating an environment conducive to sexual arousal. ▼^{EB}
22. Probe automatic thoughts that trigger the client's negative emotions such as fear, shame, anger, or grief before, during, and after sexual activity. ▼^{EB}
23. Assist the client in identifying healthy alternative thoughts that can replace dysfunctional automatic thoughts and will mediate pleasure, relaxation, and disinhibition. ▼^{EB}
24. Assist the client in making behavioral changes that challenge dysfunctional beliefs and emotions; if necessary, improve the client's understanding of developmental influences that have led to current dysfunctional sexual beliefs and/or discuss pros and cons of change. ▼^{EB}

- ▽^{EB} 16. Practice directed masturbation and sensate focus exercises alone and with partner and share feelings associated with activity. (25, 26, 27)
25. For anorgasmia, direct the client in masturbatory exercises designed to maximize arousal; assign the client graduated steps of sexual pleasuring exercises with partner that reduce her performance anxiety, and focus on experiencing bodily arousal sensations (see *Enhancing Sexuality—Therapist Guide* by Wincze or assign “Journaling the Response to Nondemand, Sexual Pleasuring [Sensate Focus]” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽^{EB}
26. For hypoactive desire, conduct Orgasm Consistency Training involving masturbatory training, sensate focus, male self-control techniques, and the coital alignment technique (see *Orgasm Consistency Training* by Hurlbert, White, and Powell). ▽^{EB}
27. Assign readings to supplement education and technique training done in session (e.g., *Enhancing Sexuality—Client Workbook* by Wincze; *Rekindling Desire* by McCarthy and McCarthy; *Becoming Orgasmic: A Sexual and Personal Growth Program for Women* by Heiman and LoPiccolo; *Because It Feels Good: A Woman’s Guide to Sexual Pleasure and Satisfaction* by Herbenick). ▽^{EB}
- ▽^{EB} 17. Report progress on graduated self-controlled vaginal penetration with a partner. (28, 29, 30)
28. Assign the client body exploration and awareness exercises that reduce inhibition and desensitize negative emotional reactions to sex. ▽^{EB}
29. Direct the client’s use of masturbation and/or vaginal

- dilator devices to reinforce relaxation and success surrounding vaginal penetration. ^{EB}▽
18. State an understanding of how family upbringing, including religious training, negatively influenced sexual thoughts, feelings, and behavior. (31, 32)
 19. Verbalize a resolution of feelings regarding sexual trauma or abuse experiences. (33, 34)
 20. Verbalize an understanding of the influence of childhood sex role models. (35)
 30. Direct the client's partner in sexual exercises that allow for client-controlled level of genital stimulation and gradually increased vaginal penetration (or assign "Journaling the Response to Nondemand, Sexual Pleasuring [Sensate Focus]" in the *Adult Psychotherapy Homework Planner* by Jongsma). ^{EB}▽
 31. Explore the role of the client's family of origin in teaching her negative attitudes regarding sexuality (or assign "Factors Influencing Negative Sexual Attitudes" in the *Adult Psychotherapy Homework Planner* by Jongsma); process toward the goal of insight and change.
 32. Explore the role of the client's religious training in reinforcing her feelings of guilt and shame surrounding her sexual behavior and thoughts; process toward the goal of insight and change.
 33. Probe the client's history for experiences of sexual trauma or abuse.
 34. Process the client's emotions surrounding an emotional trauma in the sexual arena (see the Sexual Abuse Victim chapter in this *Planner*).
 35. Explore sex role models the client has experienced in childhood or adolescence and how they have influenced the client's attitudes and behaviors.

21. Verbalize connection between previously failed intimate relationships and current fear. (36)
22. Discuss feelings surrounding a secret affair and make a termination decision regarding one of the relationships. (37, 38)
23. Openly acknowledge and discuss, if present, homosexual attraction. (39)
24. Discuss low self-esteem issues that impede sexual functioning and verbalize positive self-image. (40)
25. Communicate feelings of threat to partner that are based on perception of partner being too sexually aggressive or too critical. (41)
26. Verbalize a positive body image. (42, 43)
36. Explore the client's fears surrounding intimate relationships and whether there is evidence of repeated failure in this area.
37. Explore for any secret sexual affairs that may account for the client's sexual dysfunction with her partner.
38. Process a decision regarding the termination of one of the relationships that is leading to internal conflict over the dishonesty and disloyalty to a partner.
39. Explore for a homosexual interest that accounts for the client's heterosexual disinterest (or assign "Journal of Sexual Thoughts, Fantasies, Conflicts" in the *Adult Psychotherapy Homework Planner* by Jongsma).
40. Explore the client's fears of inadequacy as a sexual partner that led to sexual avoidance.
41. Explore the client's feelings of threat brought on by the perception of her partner as too sexually aggressive.
42. Assign the client to list assets of her body; confront unrealistic distortions and critical comments (or assign "Study Your Body—Clothed and Unclothed" in the *Adult Psychotherapy Homework Planner* by Jongsma).
43. Explore the client's feelings regarding her body image, focusing on causes for negativism.

27. Implement new coital positions and settings for sexual activity that enhance pleasure and satisfaction. (44, 45)
28. Engage in more assertive behaviors that allow for sharing sexual needs, feelings, and desires, behaving more sensuously and expressing pleasure. (46, 47)
29. Resolve conflicts or develop coping strategies that reduce stress interfering with sexual interest or performance. (48)
30. Verbalize increasing desire for and pleasure with sexual activity. (49, 50)
44. Assign books (e.g., *Sexual Awareness* by McCarthy and McCarthy; *The Gift of Sex* by Penner and Penner; *For Each Other: Sharing Sexual Intimacy* by Barbach) that provide the client with accurate sexual information and/or outline sexual exercises that disinhibit and reinforce sexual sensate focus.
45. Suggest experimentation with coital positions and settings for sexual play that may increase the client's feelings of security, arousal, and satisfaction.
46. Give the client permission for less inhibited, less constricted sexual behavior by assigning body-pleasuring exercises with partner.
47. Encourage the client to gradually explore the role of being more sexually assertive, sensuously provocative, and freely uninhibited in sexual play with partner.
48. Probe stress in areas such as work, extended family, and social relationships that distract the client from sexual desire or performance (see Anxiety, Family Conflict, and Vocational Stress chapters in this *Planner*).
49. Reinforce the client's expressions of desire for and pleasure with sexual activity.
50. Explore if there are areas of healthy sexual activity that the client may like to engage in but has been reluctant to request or discuss; encourage openness and

honesty in bringing these activities up in session and/or with her partner.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	302.71	Hypoactive Sexual Desire Disorder
	302.79	Sexual Aversion Disorder
	302.72	Female Sexual Arousal Disorder
	302.73	Female Orgasmic Disorder
	302.76	Dyspareunia
	306.51	Vaginismus
	995.53	Sexual Abuse of Child, Victim
	625.8	Female Hypoactive Sexual Desire Disorder Due to Axis III Disorder
	625.0	Female Dyspareunia Due to Axis III Disorder
	302.70	Sexual Dysfunction NOS
_____	_____	_____
_____	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
302.71	F52.22	Female Sexual Interest/Arousal Disorder
302.73	F52.31	Female Orgasmic Disorder
302.76	F52.6	Genito-Pelvic Pain/Penetration Disorder
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
302.70	F52.9	Unspecified Sexual Dysfunction

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

FINANCIAL STRESS

BEHAVIORAL DEFINITIONS

1. Indebtedness and overdue bills that exceed ability to meet monthly payments.
2. Loss of income due to unemployment.
3. Reduction in income due to change in employment status.
4. Conflict with spouse over management of money and the definition of necessary expenditures and savings goals.
5. A feeling of low self-esteem and hopelessness that is associated with the lack of sufficient income to cover the cost of living.
6. A long-term lack of discipline in money management that has led to excessive indebtedness.
7. An uncontrollable crisis (e.g., medical bills, job layoff) that has caused past due bill balances to exceed ability to make payments.
8. Fear of losing housing to foreclosure because of an inability to meet monthly mortgage payments.
9. A pattern of impulsive spending that does not consider the eventual financial consequences.

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LONG-TERM GOALS

1. Revise spending patterns to not exceed income.
2. Resolve financial crisis with a path to eliminate debt.

3. Gain a new sense of self-worth in which the substance of one's value is not attached to the capacity to do things or own things that cost money.
4. Understand personal desires, insecurities, and anxieties that make overspending possible.
5. Achieve an inner strength to control personal impulses, cravings, and desires that directly or indirectly increase debt irresponsibly.

SHORT-TERM OBJECTIVES

1. Describe the details of the current financial situation. (1, 2, 3)

2. Isolate the sources and causes of the excessive indebtedness. (4)

3. Verbalize feelings of depression, hopelessness, and/or shame that are related to financial status. (5, 6)

THERAPEUTIC INTERVENTIONS

1. Provide the client a supportive, nonjudgmental environment by being empathetic, warm, and sensitive to the fact that the topic may elicit guilt, shame, and embarrassment.
2. Explore the client's current financial situation.
3. Assist the client in compiling a complete list of financial obligations.
4. Assist in identifying, without projection of blame or holding to excuses, the causes for the financial crisis through a review of the client's history of spending.
5. Probe the client's feelings of hopelessness or helplessness that may be associated with the financial crisis.
6. Assess the depth or seriousness of the client's despondency over the financial crisis.

4. Describe any suicidal impulses that may accompany financial stress. (7)
5. Identify personal traits that make undisciplined spending possible. (8, 9)
6. Honestly describe any of own or family members' substance abuse problems that contribute to financial irresponsibility. (10, 11)
7. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (12, 13, 14, 15)
7. Assess the client's potential risk for suicidal behavior. If necessary, take steps to ensure the client's safety (see the Suicidal Ideation chapter in this *Planner*).
8. Probe the client for evidence of low self-esteem, need to impress others, loneliness, or depression that may accelerate unnecessary, unwarranted spending.
9. Assess the client for mood swings that are characteristic of bipolar disorder and could be responsible for careless spending due to the impaired judgment of manic phase (see the Bipolar Disorder—Mania chapter in this *Planner*).
10. Probe the client for excessive alcohol or other drug use by asking questions from the *CAGE* or *Michigan Alcohol Screening Test* screening instruments for substance abuse (see the Substance Use chapter in this *Planner*).
11. Explore the possibility of alcohol or drug use by the client's family members or significant other.
12. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

13. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
14. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
15. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
8. Identify priorities that should control how money is spent. (16, 17)
16. Ask the client to list the priorities that he/she believes should give direction to how his/her money is spent; process those priorities.
17. Review the client's spending history to discover what priorities and values have misdirected spending.
9. Describe the family-of-origin pattern of money management. (18)
18. Explore the client's family-of-origin patterns of earning, saving, and spending money, focusing on how those patterns are influencing his/her current financial decisions.

10. Meet with community agency personnel to apply for welfare assistance. (19, 20, 21)
11. Write a budget that balances income with expenses. (22, 23)
12. Attend a meeting with a credit counselor to gain assistance in budgeting and contacting creditors for establishment of a reasonable repayment plan. (24, 25)
13. Meet with an attorney to help reach a decision regarding filing for bankruptcy. (26)
19. Review the client's need for filing for bankruptcy, applying for welfare, and/or obtaining credit counseling.
20. Direct the client to the proper church or community resources to seek welfare assistance and support him/her in beginning the humbling application process.
21. Refer the client to government home-buyers/homeowners assistance programs to avoid foreclosure (e.g., <http://www.usa.gov/shopping/realestate/mortgages/mortgages.shtml>)
22. If financial planning is needed, refer to a professional planner or ask partners to write a current budget and a long-range savings and investment plan (consider assigning "Plan a Budget" from the *Adult Psychotherapy Homework Planner* by Jongsma or *The Budget Kit: The Common Cents Money Management Workbook* by Lawrence).
23. Review the client's budget as to reasonableness and completeness.
24. Refer the client to a nonprofit, no-cost credit counseling service for the development of a budgetary plan of debt repayment.
25. Encourage the client's attendance at all credit counseling sessions and his/her discipline of self to control spending within budgetary guidelines.
26. Refer the client to an attorney to discuss the feasibility and implications of filing for bankruptcy.

14. Verbalize a plan for seeking employment to raise level of income. (27, 28)
15. Set financial goals and make budgetary decisions with partner, allowing for equal input and balanced control over financial matters. (29, 30)
16. Keep weekly and monthly records of financial income and expenses. (31, 32)
17. Use cognitive and behavioral strategies to control the impulse to make unnecessary and unaffordable purchases. (33, 34, 35, 36)
27. Review the client's income from employment and brainstorm ways (e.g., additional part-time employment, better paying job, job training) to increase this revenue.
28. Assist the client in formulating a plan for a job search (or assign "A Vocational Action Plan" from the *Adult Psychotherapy Homework Planner* by Jongsma).
29. Encourage financial planning by the client that is done in conjunction with his/her partner.
30. Reinforce changes in managing money that reflect compromise, responsible planning, and respectful cooperation with the client's partner.
31. Encourage the client to keep a weekly and monthly record of income and outflow; review his/her records weekly, and reinforce his/her responsible financial decision-making.
32. Offer praise and ongoing encouragement of the client's progress toward debt resolution; recommend the client read *The Total Money Makeover: A Proven Plan for Financial Fitness* by Ramsey).
33. Role-play situations in which the client must resist the inner temptation to spend beyond reasonable limits, emphasizing positive self-talk that compliments self for being disciplined.
34. Role-play situations in which the client must resist external pressure to spend beyond what he/she can afford (e.g., friend's invitation to golf or go shopping, child's request

for a toy), emphasizing being graciously assertive in refusing the request.

- 35. Teach the client the cognitive strategy of asking self before each purchase: Is this purchase absolutely necessary? Can we afford this? Do we have the cash to pay for this without incurring any further debt?
- 36. Urge the client to avoid all impulse buying by delaying every purchase until after 24 hours of thought and by buying only from a prewritten list of items to buy (consider assigning “Impulsive Behavior Journal” from the *Adult Psychotherapy Homework Planner* by Jongsma).
- 18. Report instances of successful control over impulse to spend on unnecessary expenses. (37, 38)
- 37. Reinforce with praise and encouragement all of the client’s reports of resisting the urge to overspend.
- 38. Hold conjoint or family therapy session in which controlled spending is reinforced and continued cooperation is pledged by everyone.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	309.0	Adjustment Disorder with Depressed Mood
	296.4x	Bipolar I Disorder, Manic
	296.89	Bipolar II Disorder
	296.xx	Major Depressive Disorder
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Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.24	F43.22	Adjustment Disorder, With Anxiety
296.4x	F31.1x	Bipolar I Disorder, Manic
296.89	F31.81	Bipolar II Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

GRIEF/LOSS UNRESOLVED

BEHAVIORAL DEFINITIONS

1. Thoughts dominated by loss coupled with poor concentration, tearful spells, and confusion about the future.
2. Serial losses in life (i.e., deaths, divorces, jobs) that led to depression and discouragement.
3. Strong emotional response of sadness exhibited when losses are discussed.
4. Lack of appetite, weight loss, and/or insomnia as well as other depression signs that occurred since the loss.
5. Feelings of guilt that not enough was done for the lost significant other, or an unreasonable belief of having contributed to the death of the significant other.
6. Avoidance of talking on anything more than a superficial level about the loss.
7. Loss of a positive support network due to a geographic move.

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LONG-TERM GOALS

1. Begin a healthy grieving process around the loss.
2. Develop an awareness of how the avoidance of grieving has affected life and begin the healing process.
3. Complete the process of letting go of the lost significant other.
4. Resolve the loss, reengaging in old relationships and initiating new contacts with others.

SHORT-TERM OBJECTIVES

1. Tell in detail the story of the current loss that is triggering symptoms. (1, 2, 3, 4)

2. Participate in a therapy that addresses issues beyond grief

THERAPEUTIC INTERVENTIONS

1. Create a safe environment for disclosure and actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express thoughts and feelings.
2. Use empathy, compassion, and support, allowing the client to tell in detail the story of his/her recent loss.
3. Ask the client to elaborate in an autobiography the circumstances, feelings, and effects of the losses in him/her; assess the characteristics of the loss (e.g., type, suddenness, trauma), previous functioning, current functioning, and coping style.
4. Ensure that the client has self-selected therapy for grief as opposed to being “forced” into it; clarify that therapy is the client’s choice if he/she voices feeling pushed into it.
5. Assess for whether the client evidences chronic or complicated

that have arisen as a result of the loss. (5)

3. Identify how the use of substances has aided the avoidance of feelings associated with the loss. (6, 7)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)
5. Assess the client for evidence of grief or a more severe clinical syndrome secondary to the loss (e.g., depression, GAD, PTSD) and conduct or refer to an appropriate evidence-based therapy (see appropriate chapters in this *Planner*).
6. Assess the role that substance abuse has played as an escape for the client from the pain or guilt of loss.
7. Arrange for chemical dependence treatment so that grief issues can be faced while the client is clean and sober (see the Substance Use chapter in this *Planner*).
8. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
10. Assess for any issues of age, gender, or culture that could help

explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

5. Read books on the topic of grief to better understand the loss experience and to increase a sense of hope. (12, 13)
6. Identify what stages of grief have been experienced in the continuum of the grieving process. (14, 15, 16)
11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
12. Ask the client to read books on grief and loss (e.g., *Getting to the Other Side of Grief: Overcoming the Loss of a Spouse* by Zonnebelt-Smeenge and De Vries; *Good Grief* by Westberg; *When Bad Things Happen to Good People* by Kushner; *How Can It Be All Right When Everything Is All Wrong?* by Smedes); process the content.
13. Ask the parents of a deceased child to read a book on coping with the loss (e.g., *When the Bough Breaks: Forever After the Death of a Son or Daughter* by Bernstein; *Through the Eyes of a Dove: A Book for Bereaved Parents* by Courtney); process the key themes gleaned from the reading.
14. Ask the client to talk to several people about losses in their lives and how they felt and coped; process the findings.

7. Watch videos on the theme of grief and loss to compare own experience with that of the characters in the films. (17)
8. Begin verbalizing feelings associated with the loss. (18, 19, 20)
9. Attend a grief/loss support group. (21)
10. Identify how avoiding dealing with loss has negatively impacted life. (22)
11. Acknowledge dependency on lost loved one and begin to refocus life on independent actions to meet emotional needs. (23, 24)
15. Educate the client on the stages of the grieving process and answer any questions he/she may have.
16. Assist the client in identifying the stages of grief that he/she has experienced and which stage he/she is presently working through.
17. Ask the client to watch the films *Terms of Endearment*, *Dad*, *Ordinary People*, or a similar film that focuses on loss and grieving, then discuss how the characters cope with loss and express their grief.
18. Assign the client to keep a daily grief journal to be shared in therapy sessions.
19. Ask the client to bring pictures or mementos connected with his/her loss to a session and talk about them (or assign “Creating a Memorial Collage” in the *Adult Psychotherapy Homework Planner* by Jongsma).
20. Assist the client in identifying and expressing feelings connected with his/her loss.
21. Ask the client to attend a grief/loss support group and report to the therapist how he/she felt about attending.
22. Ask the client to list ways that avoidance of grieving has negatively impacted his/her life.
23. Assist the client in identifying how he/she depended upon the significant other, expressing and resolving the accompanying feelings of abandonment and of being left alone.
24. Explore the feelings of anger or guilt that surround the loss,

12. Verbalize and resolve feelings of anger or guilt focused on self or deceased loved one that interfere with the grieving process. (25, 26)
13. Verbalize resolution of feelings of guilt and regret associated with the loss. (27)
14. Decrease unrealistic thoughts, statements, and feelings of being responsible for the loss. (28)
15. Express thoughts and feelings about the deceased that went unexpressed while the deceased was alive. (29, 30, 31, 32)
25. Encourage the client to forgive self and/or deceased to resolve his/her feelings of guilt or anger; recommend books on forgiveness (e.g., *Forgive and Forget* by Smedes).
26. Use nondirective techniques (e.g., active listening, clarification, summarization, reflection) to allow the client to express and process angry feelings connected to his/her loss.
27. Assign the client to make a list of all the regrets associated with actions toward or relationship with the deceased; process the list content toward resolution of these feelings.
28. Use a cognitive therapy approach to identify the client's bias toward thoughts of personal responsibility for the loss and replace them with factual, reality-based thoughts (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma).
29. Conduct an empty-chair exercise with the client where he/she focuses on expressing to the lost loved one imagined in the chair what he/she never said while that loved one was alive.
30. Assign the client to visit the grave of the lost loved one to "talk to" the deceased and express his/her feelings.
31. Ask the client to write a letter to the lost person describing his/her fond memories and/or painful and helping the client understand the sources for such feelings.

- regretful memories, and how he/she currently feels life (or assign “Dear _____: A Letter to a Lost Loved One” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the letter in session.
16. Identify and voice positives about the deceased loved one including previous positive experiences, positive characteristics, positive aspects of the relationship, and how these things may be remembered. (33, 34)
 17. Attend and participate in a family therapy session focused on each member sharing his/her experience with grief. (35)
 18. Reengage in activities with family, friends, coworkers, and others. (36, 37)
 32. Assign the client to write to the deceased loved one with a special focus on his/her feelings associated with the last meaningful contact with that person.
 33. Ask the client to discuss and/or list the positive aspects of and memories about his/her relationship with the lost loved one; reinforce the client’s expression of positive memories and emotions (e.g., smiling, laughing); encourage the client to share these thoughts with supportive loved ones.
 34. Assist the client in engaging in behaviors that celebrate the positive memorable aspects of the loved one and his/her life (e.g., placing memoriam in newspaper on anniversary of death, volunteering time to a favorite cause of the deceased person).
 35. Conduct a family and/or group session with the client participating, where each member talks about his/her experience related to the loss; encourage supportive interactions among family members.
 36. Assist the client in recommitting and reengaging in the primary social positive roles in which he/she has functioned prior to the loss.
 37. Promote behavioral activation by assisting the client in listing activities which he/she previously enjoyed but has not engaged in

since experiencing the loss and then encourage reengagement in these activities (or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma).

19. Report decreased time spent each day focusing on the loss. (38, 39)

38. Develop a grieving ritual with an identified feeling state (e.g., dress in dark colors, preferably black, to indicate deep sorrow) which the client may focus on near the anniversary of the loss. Process what he/she received from the ritual.

39. Suggest that the client set aside a specific time-limited period each day to focus on mourning his/her loss. After each day’s time is up, the client will resume regular activities and postpone grieving thoughts until the next scheduled time. For example, mourning times could include putting on dark clothing and/or sad music; clothing would be changed when the allotted time is up.

20. Develop and enact act(s) of penitence. (40)

40. Encourage the parents to allow the client to participate in a memorial service, funeral service, or other grieving rituals.

21. Implement acts of spiritual faith as a source of comfort and hope. (41)

41. Encourage the client to rely upon his/her spiritual faith promises, activities (e.g., prayer, meditation, worship, music), and fellowship as sources of support.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	V62.82	Bereavement
	309.0	Adjustment Disorder With Depressed Mood
	309.3	Adjustment Disorder With Disturbance of Conduct
	300.4	Dysthymic Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
V62.82	Z63.4	Uncomplicated Bereavement
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.24	F43.22	Adjustment Disorder, With Anxiety
309.28	F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
309.4	F43.25	Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct
300.4	F34.1	Persistent Depressive Disorder

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IMPULSE CONTROL DISORDER

BEHAVIORAL DEFINITIONS

1. A tendency to act too quickly without careful deliberation, resulting in numerous negative consequences.
2. Loss of control over aggressive impulses resulting in assault, self-destructive behavior, or damage to property.
3. Deliberate and purposeful fire-setting on more than one occasion.
4. Persistent and recurrent maladaptive gambling behavior.
5. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
6. Recurrent pulling out of one's hair resulting in noticeable hair loss.
7. Desire to be satisfied almost immediately and a decreased ability to delay pleasure or gratification.
8. A history of acting out in at least two areas that are potentially self-damaging (e.g., spending money, sexual activity, reckless driving, addictive behavior).
9. Overreactivity to mildly aversive or pleasure-oriented stimulation.
10. A sense of tension or affective arousal before engaging in the impulsive behavior (e.g., kleptomania, pyromania).
11. A sense of pleasure, gratification, or release at the time of committing the ego-dystonic, impulsive act.
12. Difficulty waiting for things—that is, restless standing in line, talking out over others in a group, and the like.

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LONG-TERM GOALS

1. Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.
2. Reduce thoughts that trigger impulsive behavior and increase self-talk that controls behavior.
3. Learn to stop, listen, and think before acting.

SHORT-TERM OBJECTIVES

1. Identify the impulsive behaviors that have been engaged in over the last six months. (1)
2. List the reasons or rewards that lead to continuation of an impulsive pattern. (2, 3)
3. Disclose any history of substance use that may contribute to and complicate the treatment of Impulse Control Disorder. (4)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM*

THERAPEUTIC INTERVENTIONS

1. Review the client's behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity.
2. Explore whether the client's impulsive behavior is triggered by anxiety and maintained by anxiety relief rewards; assess for bipolar manic disorder or ADHD.
3. Ask the client to make a list of the positive things he/she gets from impulsive actions and process it with the therapist.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the

diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. List the negative consequences that accrue to self and others as a result of impulsive behavior. (9, 10, 11)
6. Identify impulsive behavior's antecedents, mediators, and consequences. (12, 13)
7. Participate in imaginal exposure sessions to decrease the urge to act impulsively. (14, 15)
9. Assign the client to write a list of the negative consequences that have occurred because of impulsivity (or assign "Recognizing the Negative Consequences of Impulsive Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).
10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others.
11. Confront the client's denial of responsibility for the impulsive behavior or the negative consequences (or assign "Accept Responsibility for Illegal Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).
12. Ask the client to keep a log of impulsive acts (time, place, feelings, thoughts, what was going on prior to the act, and what was the result); process log content to discover triggers and reinforcers (or assign "Impulsive Behavior Journal" from the *Adult Psychotherapy Homework Planner* by Jongsma).
13. Explore the client's past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes.
14. Assist the client in composing a script describing a typical situation in which impulsive behavior occurs, the urge to act, physical symptoms, expected negative consequences, and, finally, resisting the urge.

8. Participate in an *in vivo* exposure treatment procedure. (16, 17, 18, 19)
15. Use the client's script in an imaginal exposure session in which the client is relaxed and the script is read repeatedly.
16. Direct and assist the client in construction of a hierarchy of feared internal and external impulsive behavior cues.
17. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's impulsive actions.
18. Select initial exposures (imaginal or *in vivo*) to the internal and/or external impulsive behavior cues that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; or *Treatment of Obsessive-Compulsive Disorder* by McGinn and Sanderson).
19. Assign the client a homework exercise in which he/she repeats the exposure to the internal and/or external impulsive behavior cues using response prevention and restructured cognitions between sessions and records responses (or assign "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during next session, reinforcing success and providing corrective feedback toward improvement (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).

9. Verbalize a clear connection between impulsive behavior and negative consequences to self and others. (10, 20)
10. Before acting on behavioral decisions, frequently review them with a trusted friend or family member for feedback regarding possible consequences. (21, 22)
11. Utilize cognitive methods to control trigger thoughts and reduce impulsive reactions to those trigger thoughts. (13, 23, 24)
10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others.
20. Reinforce the client's verbalized acceptance of responsibility for and connection between impulsive behavior and negative consequences.
21. Conduct a session with the client and his/her partner to develop a contract for receiving feedback prior to impulsive acts.
22. Brainstorm with the client who he/she could rely on for trusted feedback regarding action decisions; use role-play and modeling to teach how to ask for and accept this help.
13. Explore the client's past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes.
23. Teach the client cognitive methods (thought-stopping, thought substitution, reframing, etc.) for gaining and improving control over impulsive urges and actions.
24. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic

- thoughts associated with education and his/her ability to learn.
12. Use relaxation exercises to control anxiety, urges, and reduce consequent impulsive behavior. (25, 26, 27)
 13. Utilize behavioral strategies to manage urges for impulsive action. (28, 29, 30)
 25. Teach the client relaxation skills (e.g., progressive muscle relaxation, imagery, diaphragmatic breathing, verbal cues for deep relaxation), how to discriminate better between relaxation and tension, as well as how to apply these skills to coping with situations associated with impulsive urges (e.g., see *Progressive Relaxation Training* by Bernstein and Borkovec).
 26. Assign the client homework each session in which he or she practices relaxation exercises daily for at least 15 minutes and applies the technique to impulsive trigger situations; review the exercises, reinforcing success while providing corrective feedback toward improvement.
 27. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow).
 28. Teach the use of positive behavioral alternatives to cope with impulsive urges (e.g., talking to someone about the urge, taking a time out to delay any reaction, calling a friend or family member, engaging in physical exercise, leaving credit cards with a family member, creating needed item shopping lists to avoid impulsive buying, avoiding use of police and fire scanners, etc.).

14. List instances where “stop, listen, think, and act” has been implemented, citing the positive consequences. (31, 32)
15. Describe any history of manic or hypomanic behavior related to a mood disorder. (33)
16. Identify situations in which there has been a loss of control over aggressive impulses resulting in destructive or assaultive behavior. (34)
17. Comply with the recommendations from a physician evaluation regarding the
29. Review the client’s implementation of behavioral coping strategies to reduce urges and tension; reinforce success and redirect for failure.
30. Teach the client covert sensitization in which he/she imagines a negative consequence (e.g., going to jail) whenever the desire to act impulsively appears (e.g., the desire to steal); assign as homework; review, reinforcing success and problem-solving obstacles until internalized by the client.
31. Using modeling, role-playing, and behavior rehearsal, teach the client how to use “stop, listen, and think” before acting in several current situations.
32. Review and process the client’s use of “stop, listen, think, and act” in day-to-day living and identify the positive consequences.
33. Assess the client for a mood disorder that includes manic episodes with a lack of judgment over impulsive behavior and its consequences (see the Bipolar Disorder—Mania chapter in this *Planner*).
34. Explore the client’s history of explosive anger management problems; include this as presenting problem if there have been several such episodes of aggressiveness grossly out of proportion to any precipitating psychosocial stressor (see the Anger Control Problems chapter in this *Planner*).
35. Refer the client to a physician for an evaluation for a psychotropic medication prescription.

- necessity for psychopharmacological intervention. (35, 36)
18. Implement a reward system for replacing impulsive actions with reflection on consequences and choosing wise alternatives. (37, 38)
 19. Learn and implement problem-solving skills to reduce impulsive behavior. (39, 40)
 20. Read recommended material on overcoming impulsive behavior. (41)
 36. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals.
 37. Assist the client in identifying rewards that would be effective in reinforcing himself/herself for suppressing impulsive behavior.
 38. Assist the client and significant others in developing and putting into effect a reward system for deterring the client's impulsive actions.
 39. Teach the client problem-resolution skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating outcome, and readjusting plan as necessary).
 40. Use modeling and role-playing with the client to apply the problem-solving approach to his/her urge for impulsive action (or assign "Problem-Solving: An Alternative to Impulsive Action" from the *Adult Psychotherapy Homework Planner* by Jongsma); encourage implementation of action plan, reinforcing success and redirecting for failure.
 41. Recommend the client read material on coping with impulsive urges (e.g., *Stop Me Because I Can't Stop Myself: Taking Control of Impulsive Behavior* by Grant and Fricchione; *Overcoming Impulse*

Control Problems: A Cognitive-Behavioral Therapy Program—Workbook by Grant, Donahue, and Odlaug).

21. Attend a self-help recovery group. (42)

42. Refer the client to a self-help recovery group (e.g., 12-step program, ADHD group, Rational Recovery, etc.) designed to help terminate self-destructive impulsivity; process his/her experience in the group.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I: 312.34 Intermittent Explosive Disorder
 312.32 Kleptomania
 312.31 Pathological Gambling
 312.39 Trichotillomania
 312.30 Impulse Control Disorder NOS
 312.33 Pyromania
 310.1 Personality Change Due to Axis III Disorder

Axis II: 301.7 Antisocial Personality Disorder
 301.83 Borderline Personality Disorder
 799.9 Diagnosis Deferred
 V71.09 No Diagnosis

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
312.34	F63.81	Intermittent Explosive Disorder
312.32	F63.81	Kleptomania
312.31	F63.0	Gambling Disorder
312.39	F63.2	Trichotillomania
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
312.33	F63.1	Pyromania
310.1	F07.0	Personality Change Due to Another Medical Condition
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

INTIMATE RELATIONSHIP CONFLICTS

BEHAVIORAL DEFINITIONS

1. Frequent or continual arguing with the partner.
2. Lack of communication with the partner.
3. A pattern of angry projection of responsibility for the conflicts onto the partner.
4. Marital separation.
5. Pending divorce.
6. Involvement in multiple intimate relationships at the same time.
7. Physical and/or verbal abuse in a relationship.
8. A pattern of superficial or no communication, infrequent or no sexual contact, excessive involvement in activities (work or recreation) that allows for avoidance of closeness to the partner.
9. A pattern of repeated broken, conflictual relationships due to personal deficiencies in problem-solving, maintaining a trust relationship, or choosing abusive or dysfunctional partners.

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LONG-TERM GOALS

1. Develop the necessary skills for effective, open communication, mutually satisfying sexual intimacy, and enjoyable time for companionship within the relationship.
2. Increase awareness of own role in the relationship conflicts.

3. Learn to identify escalating behaviors that lead to abuse.
4. Make a commitment to one intimate relationship at a time.
5. Accept the termination of the relationship.
6. Rebuild positive self-image after acceptance of the rejection associated with the broken relationship.

SHORT-TERM OBJECTIVES

1. Attend and actively participate in conjoint sessions with the partner. (1)

2. Identify problems and strengths in the relationship, including one’s own role in each. (2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Develop a level of trust with the couple by creating a therapeutic environment in which each can express problems, wants, and goals; clarify ground rules; establish oneself as a neutral moderator.

2. Assess current, ongoing problems in the relationship, including possible abuse/neglect, substance use, communication, conflict resolution, as well as home environment (if domestic violence is present, plan for safety and avoid early use of conjoint sessions; see the Physical Abuse chapter in *The Couples Psychotherapy Treatment Planner* by O’Leary, Heyman, and Jongsma).

3. Assess strengths in the relationship that could be enhanced during the therapy to facilitate the accomplishment of therapeutic goals.

3. Acknowledge the connection between substance abuse and the conflicts present within the relationship. (5)
4. Chemically dependent partner agrees to pursue substance treatment individually or with partner. (6)
5. Complete psychological testing designed to assess the marital relationship and track treatment progress. (7)
6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)
4. Assign the couple a between-sessions task recording in journals the positive and negative things about the significant other and the relationship (or assign “Positive and Negative Contributions to the Relationship: Mine and Yours” in the *Adult Psychotherapy Homework Planner* by Jongsma); ask the couple not to show their journal material to each other until the next session, when the material will be processed.
5. Explore with the couple the role of substance abuse in precipitating conflict and/or abuse within the relationship.
6. Solicit an agreement for substance abuse treatment for the chemically dependent partner and refer to an evidence-based individual therapy or to Behavioral Couples Therapy for substance abuse treatment (see the Substance Use chapter in this *Planner*).
7. Administer a measure of overall marital adjustment (e.g., *The Dyadic Adjustment Scale*), and/or satisfaction (e.g., *Marital Satisfaction Inventory-Revised*) to supplement interview as needed; readminister as indicated to assess treatment progress.
8. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a

concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 10. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 11. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼ 7. Make a commitment to change specific behaviors that have been identified by self or the partner. (12)
12. Process the list of positive and problematic features of each partner and the relationship; ask couple to agree to work on changes he/she needs to make to improve the relationship, generating a list of targeted changes (or assign “How Can We Meet Each Other’s Needs

and Desires?” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}

- ▼^{EB} 8. Each partner negotiates and signs a contract to agree to increase positive behaviors that each partner desires. (13)
- ▼^{EB} 9. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the relationship. (14, 15, 16)
- ▼^{EB} 10. Learn and implement problem-solving and conflict resolution skills. (17, 18, 19)
- 13. Develop a contract identifying negotiated behavioral changes that each partner desires within the relationship; ask the couple to sign the contract.^{EB}
- 14. Assist the couple in identifying conflicts that can be addressed using communication, conflict-resolution, and/or problem-solving skills (see “Behavioral Marital Therapy” by Holtzworth-Munroe and Jacobson).^{EB}
- 15. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.^{EB}
- 16. Assign the couple a homework exercise to use and record newly learned communication skills; process results in session, providing corrective feedback toward improvement.^{EB}
- 17. Review how newly learned communication skills can be applied to conflict resolution through calm, respectful, effective dialogue; role-play application of this skill to a present conflict situation.^{EB}
- 18. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the couple

problem-solving and conflict resolution skills including defining the problem constructively and specifically, brainstorming options, evaluating options, compromise, choosing options and implementing a plan, evaluating the results. ▽

19. Assign the couple a homework exercise to use and record newly learned problem-solving and conflict resolution skills (or assign “Applying Problem-Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session. ▽
- ▽ 11. Learn and implement cognitive therapy techniques to replace unrealistic, maladaptive thoughts, feelings, and actions with those facilitative of the relationship. (20, 21)
20. Use cognitive therapy techniques to restructure the clients’ biased cognitions (e.g., mind-reading, blaming), modify maladaptive emotional responses (e.g., rage) and inappropriate behaviors (e.g., verbal aggression) within the relationship (see *Enhanced Cognitive Behavioral Therapy for Couples* by Epstein and Baucom) ▽
21. Identify the couple’s irrational beliefs and unrealistic expectations regarding relationships and then assist them in adopting more realistic beliefs and expectations of each other and of the relationship (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
- ▽ 12. Accept partner’s existing characteristics that are unlikely to change but do not jeopardize the relationship. (22)
22. Help the couple build tolerance of each other’s differences by seeing the positive side of such differences to balance their awareness of drawbacks (see *Integrative Couple*

- Therapy* by Jacobson and Christensen).^{EB}▽
- ▽^{EB} 13. Increase flexibility of expectations, willingness to compromise, and acceptance of irreconcilable differences. (23)
- ▽^{EB} 14. Understand the origin of each other's negative emotions and reactions and develop more constructive interactions that fill needs. (24, 25, 26)
15. Gain insight into how past relationship experiences influence current relationship problems. (27)
23. Teach both partners the key concepts of flexibility, compromise, sacrifice of wants, and acceptance of differences toward increased understanding, empathy, intimacy, and compassion for each other (see *Integrative Couple Therapy* by Jacobson and Christensen).^{EB}▽
24. For mild to moderately distressed couples, convey a model to the clients that conceptualizes negative emotions and behavioral reactions as reflecting vulnerability and attachment insecurities (see *Emotion-Focused Couples Therapy* by Greenberg and Goldman; “Emotionally Focused Couples Therapy” by Johnson).^{EB}▽
25. Encourage the clients to recognize, reframe, and express these insecurities toward resolving negative emotional and behavioral reactions.^{EB}▽
26. Assist the clients in developing more constructive interactions that satisfy attachment needs such as increased intimacy and expressions of love (or assign “How Can We Meet Each Other's Needs and Desires?” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
27. Conduct an insight-oriented couples therapy identifying how past relationship injuries (e.g., betrayal of trust) create current vulnerabilities that cause relationship conflicts (e.g., fear of intimacy); help the couple to separate the past from the present

(see *Insight Oriented Marital Therapy* by Wills).

16. Identify any patterns of destructive and/or abusive behavior in the relationship. (28, 29)
17. Implement a “time out” signal that either partner may give to stop interaction that may escalate into abuse. (30, 31, 32)
18. Initiate verbal and physical affection behaviors toward the partner. (33)
19. Increase time spent in enjoyable contact with the partner. (34)
28. Assess current patterns of destructive and/or abusive behavior for each partner, including those that existed in each family of origin (if domestic violence is present, plan for safety and avoid early use of conjoint sessions; see the Physical Abuse chapter in *The Couples Psychotherapy Treatment Planner* by O’Leary, Heyman, and Jongsma).
29. Ask each partner to make a list of escalating behaviors that occur prior to abusive behavior.
30. Assist the partners in identifying a clear verbal or behavioral signal to be used by either partner to terminate interaction immediately if either fears impending abuse.
31. Solicit a firm agreement from both partners that the “time out” signal will be responded to favorably without debate.
32. Assign implementation and recording the use of the “time out” signal and other conflict resolution skills in daily interaction (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma).
33. Encourage each partner to increase the use of verbal and physical affection; address resistance surrounding initiating affectionate or sexual interactions with the partner.
34. Assist the couple in identifying and planning rewarding social/recreational activities that can be shared with the partner (or assign

- “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma).
20. Participate in an evaluation to identify or rule out sexual dysfunction and participate in appropriate treatment, if indicated. (35, 36)
 21. Commit to the establishment of healthy, mutually satisfying sexual attitudes and behavior that is not a reflection of destructive earlier experiences. (37, 38)
 22. Identify the cause and consequences of the partner’s infidelity, as well as each other’s goals of therapy. (39, 40)
 35. Gather from each partner a thorough sexual history to determine areas of strength and to identify areas of dysfunction (see the Female Sexual Dysfunction and Male Sexual Dysfunction chapters in this *Planner*).
 36. Refer the client to a specialist for a diagnostic evaluation of sexual dysfunction (e.g., rule-out of medical or substance etiology), with recommendation for appropriate evidence-based treatment (e.g., medication, sex therapy, surgery).
 37. In a conjoint session identify sexual behavior, patterns, activities, and beliefs of each partner and the extended family (or assign “Factors Influencing Negative Sexual Attitudes” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 38. Assist each partner in committing to attempt to develop healthy, mutually satisfying sexual beliefs, attitudes, and behavior that are independent of previous childhood, personal, or family training or experience.
 39. Assist the couple in identifying the cause(s) and consequences of the infidelity; clarify the couple’s motivation and goals of therapy.
 40. Assign the clients to read *After the Affair* by Spring, or *Getting Past the Affair: A Program to Help You Cope, Heal, and Move On—Together or Apart* by Synder,

- Baucom, and Gordon; process key concepts gathered from the reading in conjoint sessions with the therapist.
- 23. Verbalize acceptance of the loss of the relationship. (41, 42, 43)
 - 24. Implement increased socialization activities to cope with loneliness. (44, 45)
 - 41. Explore and clarify feelings associated with loss of the relationship.
 - 42. Refer the client to a support group or divorce seminar to assist in resolving the loss and in adjusting to the new life.
 - 43. Assign the client to read *Rebuilding: When Your Relationship Ends* by Fisher, or *Surviving Separation and Divorce: A Woman's Guide* by Oberlin; process key concepts.
 - 44. Support the client in his/her adjustment to living alone and being single; encourage him/her in accepting some time in being alone and in making concrete plans for social contact.
 - 45. Inform the client of opportunities within the community that assist him/her in building new social relationships.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.34	Intermittent Explosive Disorder
	309.0	Adjustment Disorder With Depressed Mood

309.24	Adjustment Disorder With Anxiety
300.4	Dysthymic Disorder
300.00	Anxiety Disorder NOS
311	Depressive Disorder NOS
309.81	Posttraumatic Stress Disorder
V61.10	Partner Relational Problem
_____	_____
_____	_____


Axis II:

301.20	Schizoid Personality Disorder
301.81	Narcissistic Personality Disorder
301.9	Personality Disorder NOS
_____	_____
_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
312.34	F63.81	Intermittent Explosive Disorder
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.24	F43.22	Adjustment Disorder, With Anxiety
300.4	F34.1	Persistent Depressive Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
311	F32.9	Unspecified Depressive Disorder
311	F32.8	Other Specified Depressive Disorder
309.81	F43.10	Posttraumatic Stress Disorder
301.20	F60.1	Schizoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
V61.03	Z63.5	Disruption of Family by Separation or Divorce

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and DSM-5 Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

LEGAL CONFLICTS

BEHAVIORAL DEFINITIONS

1. Legal charges pending.
2. On parole or probation subsequent to legal charges.
3. Legal pressure has been central to the decision to enter treatment.
4. A history of criminal activity leading to numerous incarcerations.
5. Most arrests are related to alcohol or drug abuse.
6. Pending divorce accompanied by emotional turmoil.
7. Fear of loss of freedom due to current legal charges.

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LONG-TERM GOALS

1. Accept and responsibly respond to the mandates of court.
2. Understand how chemical dependence has contributed to legal problems and accept the need for recovery.
3. Accept responsibility for decisions and actions that have led to arrests and develop higher moral and ethical standards to govern behavior.
4. Internalize the need for treatment so as to change values, thoughts, feelings, and behavior to a more prosocial position.
5. Become a responsible citizen in good standing within the community.

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SHORT-TERM OBJECTIVES

1. Describe the behavior that led to current involvement with the court system. (1)
2. Verbalize the role drug and/or alcohol abuse has played in legal problems. (2, 3)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)

THERAPEUTIC INTERVENTIONS

1. Explore the client’s behavior that led to legal conflicts and assess whether it fits a pattern of antisocial behavior (see the Antisocial Behavior chapter in this *Planner*).
2. Explore how chemical dependence may have contributed to the client’s legal conflicts.
3. Confront the client’s denial of chemical dependence by reviewing the various negative consequences of addiction that have occurred in his/her life.
4. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary

- to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 8. Reinforce the client's need for a plan for recovery and sobriety as a means of improving judgment and control over behavior (see the Substance Use chapter in this *Planner*).
 9. Monitor and reinforce the client's sobriety, using physiological measures to confirm, if advisable.
 10. Encourage and facilitate the client in meeting with an attorney to discuss plans for resolving legal issues.
 11. Monitor and encourage the client to keep appointments with court officers.
4. Maintain sobriety in accordance with rules of probation/parole. (8, 9)
 5. Obtain counsel and meet to make plans for resolving legal conflicts. (10)
 6. Make regular contact with court officers to fulfill sentencing requirements. (11)

7. Verbalize and accept responsibility for the series of decisions and actions that eventually led to illegal activity. (12)
8. State values that affirm behavior within the boundaries of the law. (13, 14)
9. Verbalize how the emotional state of anger, frustration, helplessness, or depression has contributed to illegal behavior. (15, 16, 17)
10. (12)
11. (12)
12. Confront the client's denial and projection of responsibility onto others for his/her own illegal actions (or assign "Accept Responsibility for Illegal Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).
13. Assist the client in clarification of values that allow him/her to act illegally.
14. Teach the values associated with respecting legal boundaries and the rights of others as well as the consequences of crossing these boundaries.
15. Probe the client's negative emotional states that could contribute to his/her illegal behavior.
16. Refer the client for ongoing counseling to deal with emotional conflicts and antisocial impulses (see Antisocial Behavior, Anger Control Problems, or Unipolar Depression chapters in this *Planner*).
17. Recommend that the client read material on controlling emotions (e.g., *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by McKay, Davis, and Fanning; *The Anger Control Workbook* by McKay and Rogers; *A Cognitive Behavioral Workbook for Depression: A Step-by-Step Program* by Knaus; *Overcoming Impulse Control Problems: A Cognitive-Behavioral Therapy Program—Workbook* by Grant, Donahue, and Odlaug).

10. Identify the causes for the negative emotional state that was associated with illegal actions. (18, 19)
11. Identify and replace cognitive distortions that foster antisocial behavior. (20, 21, 22)
12. Attend an anger control group. (23)
18. Explore causes for the client's underlying negative emotions that consciously or unconsciously fostered his/her criminal behavior.
19. Interpret the client's antisocial behavior that is linked to current or past emotional conflicts to foster insights and resolution.
20. Use the cognitive restructuring process (i.e., teaching the connection between thoughts, feelings, and actions; identifying relevant automatic thoughts and their underlying beliefs or biases; challenging the biases; developing alternative positive perspectives; testing biased and alternative beliefs through behavioral experiments) to assist the client in replacing negative automatic thoughts associated with illegal behavior.
21. Reinforce the client for developing and implementing positive, reality-based messages to replace the distorted, negative self-talk associated with illegal behavior.
22. Assign the client a homework exercise (e.g., "Crooked Thinking Leads to Crooked Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma) in which he/she identifies negative self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments; review and reinforce success, providing corrective feedback toward improvement.
23. Refer the client to an impulse control or anger management group.

- 13. Identify ways to meet life needs (i.e., social and financial) without resorting to illegal activities. (24, 25)
- 14. Attend class to learn how to successfully seek employment. (26)
- 15. Verbalize an understanding of the importance of honesty in earning the trust of others and esteem for self. (27)
- 16. Develop and implement a plan for restitution for illegal activity. (28, 29)
- 24. Explore with the client ways he/she can meet social and financial needs without involvement with illegal activity (e.g., employment, further education or skill training, spiritual enrichment group).
- 25. Educate the client on the difference between antisocial and prosocial behaviors; assist him/her in writing a list of ways to show respect for the law, help others, and work regularly.
- 26. Refer the client to an ex-offender center for assistance in obtaining employment.
- 27. Help the client understand the importance of honesty in earning the trust of others and self-respect.
- 28. Assist the client in seeing the importance of restitution to self-worth; help him/her develop a plan to provide restitution for the results of his/her behavior (or assign “How I Have Hurt Others” and/or “Letter of Apology” from the *Adult Psychotherapy Homework Planner* by Jongsma).
- 29. Review the client’s implementation of his/her restitution plan; reinforce success and redirect for failure.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	303.90	Alcohol Dependence
	304.80	Polysubstance Dependence
	312.32	Kleptomania
	V71.01	Adult Antisocial Behavior
	309.3	Adjustment Disorder With Disturbance of Conduct
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Axis II:	301.7	Antisocial Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
312.32	F63.81	Kleptomania
V71.01	Z72.811	Adult Antisocial Behavior
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
301.7	F60.2	Antisocial Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

LOW SELF-ESTEEM

BEHAVIORAL DEFINITIONS

1. Inability to accept compliments.
2. Makes self-disparaging remarks; sees self as unattractive, worthless, a loser, a burden, unimportant; takes blame easily.
3. Lack of pride in grooming.
4. Difficulty in saying no to others; assumes not being liked by others.
5. Fear of rejection by others, especially peer group.
6. Lack of any goals for life and setting of inappropriately low goals for self.
7. Inability to identify positive characteristics of self.
8. Anxious and uncomfortable in social situations.

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LONG-TERM GOALS

1. Elevate self-esteem.
2. Develop a consistent, positive self-image.
3. Demonstrate improved self-esteem through more pride in appearance, more assertiveness, greater eye contact, and identification of positive traits in self-talk messages.
4. Establish an inward sense of self-worth, confidence, and competence.

5. Interact socially without undue distress or disability.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

1. Acknowledge feeling less competent than most others. (1, 2)

2. Participate in a therapy for issues beyond self-esteem. (3)

3. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar depression. (4)

4. Provide behavioral, emotional, and attitudinal information toward an assessment of

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.

2. Explore the client’s assessment of himself/herself and what is verbalized as the basis for negative self-perception.

3. Assess whether the client’s low self-esteem is occurring within a clinical syndrome (e.g., social anxiety disorder, depression), and, if so, conduct or refer to an appropriate evidence-based treatment (e.g., see the Social Anxiety and/or Unipolar Depression chapters in this *Planner*).

4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

5. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems”

specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

(e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Increase insight into the historical and current sources of low self-esteem. (9, 10)
6. Decrease the frequency of negative self-descriptive statements and increase frequency of positive self-descriptive statements. (11, 12, 13)
7. Identify and replace negative self-talk messages used to reinforce low self-esteem. (14, 15)
9. Help the client become aware of his/her fear of rejection and its connection with past rejection or abandonment experiences; begin to contrast past experiences of pain with present experiences of acceptance and competence.
10. Discuss, emphasize, and interpret the client's incidents of abuse (emotional, physical, and sexual) and how they have impacted his/her feelings about himself/herself.
11. Assist the client in becoming aware of how he/she expresses or acts out negative feelings about himself/herself.
12. Help the client reframe his/her negative assessment of himself/herself.
13. Assist the client in developing positive self-talk as a way of boosting his/her confidence and self-image (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
14. Help the client identify his/her distorted, negative beliefs about self and the world and replace these messages with more realistic, affirmative messages (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma or read *What to Say When You Talk to Yourself* by Helmstetter).
15. Ask the client to complete and process self-esteem-building exercises from recommended self-help books (e.g., *Ten Days to Self-Esteem!* by Burns; *The Self-Esteem Companion* by McKay, Fanning,

Honeychurch, and Sutker; *10 Simple Solutions for Building Self-Esteem* by Schialdi).

8. Identify any secondary gain that is received by speaking negatively about self and refusing to take any risks. (16, 17)
9. Decrease the verbalized fear of rejection while increasing statements of self-acceptance. (18, 19)
10. Identify and engage in activities that would improve self-image by being consistent with one's values. (20, 21)
11. Increase eye contact and interaction with others. (22, 23, 24)
16. Teach the client the meaning and power of secondary gain in maintaining negative behavior patterns.
17. Assist the client in identifying how self-disparagement and avoidance of risk-taking could bring secondary gain (e.g., praise from others, others taking over responsibilities).
18. Ask the client to make one positive statement about himself/herself daily and record it on a chart or in a journal) or assign "Replacing Fears with Positive Messages" in the *Adult Psychotherapy Homework Planner* by Jongsma).
19. Verbally reinforce the client's use of positive statements of confidence and accomplishments.
20. Help the client analyze his/her values and the congruence or incongruence between them and the client's daily activities.
21. Identify and assign activities congruent with the client's values; process them toward improving self-concept and self-esteem.
22. Assign the client to make eye contact with whomever he/she is speaking to; process the feelings associated with eye contact (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma).
23. Provide feedback to the client when he/she is observed avoiding

eye contact with others toward increasing the behavior and extinguishing anxiety associated with it.

12. Take responsibility for daily grooming and personal hygiene. (25)
13. Identify positive traits and talents about self. (26, 27)
14. Demonstrate an increased ability to identify and express personal feelings. (28, 29)
15. Articulate a plan to be proactive in trying to get identified needs met. (30, 31, 32)
24. Use role-playing and behavioral rehearsal to improve the client's social skills in greeting people and carrying a conversation (suggest the client read *Shyness: What It Is and What to Do About It* by Zimbardo).
25. Monitor and give feedback to the client on his/her grooming and hygiene.
26. Assign the client the exercise of identifying his/her positive physical characteristics in a mirror to help him/her become more comfortable with himself/herself.
27. Ask the client to keep building a list of positive traits and have him/her read the list at the beginning and end of each session (or assign "Acknowledging My Strengths" or "What Are My Good Qualities?" in the *Adult Psychotherapy Homework Planner* by Jongsma); reinforce the client's positive self-descriptive statements.
28. Assign the client to keep a journal of feelings on a daily basis.
29. Assist the client in identifying and labeling emotions.
30. Assist the client in identifying and verbalizing his/her needs, met and unmet.
31. Conduct a conjoint or family therapy session in which the client is supported in expression of unmet needs.

- 16. Positively acknowledge verbal compliments from others. (33)
- 17. Increase the frequency of assertive behaviors. (34)
- 18. Form realistic, appropriate, and attainable goals for self in all areas of life. (35, 36)
- 19. Take verbal responsibility for accomplishments without discounting. (37)
- 32. Assist the client in developing a specific action plan to get each need met (or assign “Satisfying Unmet Emotional Needs” in the *Adult Psychotherapy Homework Planner* by Jongsma).
- 33. Assign the client to be aware of and acknowledge graciously (without discounting) praise and compliments from others.
- 34. Train the client in assertiveness or refer him/her to a group that will educate and facilitate assertiveness skills via lectures and assignments.
- 35. Help the client analyze his/her goals to make sure they are realistic and attainable.
- 36. Assign the client to make a list of goals for various areas of life and a plan for steps toward goal attainment.
- 37. Ask the client to list accomplishments; process the integration of these into his/her self-image.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.23	Social Phobia (Social Anxiety Disorder)
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	309.9	Adjustment Disorder Unspecified
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Axis II:	301.82	Avoidant Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
300.02	F41.1	Generalized Anxiety Disorder
319	F70	Intellectual Disability, Mild
V62.89	R41.83	Borderline Intellectual Functioning

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

MALE SEXUAL DYSFUNCTION

BEHAVIORAL DEFINITIONS

1. Describes consistently very low or no pleasurable anticipation of or desire for sexual activity.
2. Strongly avoids and/or is repulsed by any and all sexual contact in spite of a relationship of mutual caring and respect.
3. Recurrently experiences a lack of the usual physiological response of sexual excitement and arousal (attaining and/or maintaining an erection).
4. Reports a consistent lack of a subjective sense of enjoyment and pleasure during sexual activity.
5. Experiences a persistent delay in or absence of reaching ejaculation after achieving arousal and in spite of sensitive sexual pleasuring by a caring partner.
6. Describes genital pain experienced before, during, or after sexual intercourse.

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LONG-TERM GOALS

1. Increase desire for and enjoyment of sexual activity.
2. Attain and maintain physiological excitement response during sexual intercourse.

3. Reach ejaculation with a reasonable amount of time, intensity, and focus to sexual stimulation.
4. Eliminate pain and achieve a presence of subjective pleasure before, during, and after sexual intercourse.

SHORT-TERM OBJECTIVES

1. Provide a detailed sexual history that explores current problems and past experiences that have influenced sexual attitudes, feelings, and behavior. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Obtain a detailed sexual history that examines the client’s current adult sexual functioning as well as his childhood and adolescent sexual experiences, level and sources of sexual knowledge, typical sexual practices and their frequency, medical history, drug and alcohol use, and lifestyle factors.
2. Assess the client’s attitudes and fund of knowledge regarding sex, emotional responses to it, and self-talk that may be contributing to the dysfunction.
3. Explore the client’s family-of-origin for factors that may be contributing to the dysfunction such as negative attitudes regarding sexuality, feelings of inhibition, low self-esteem, guilt, fear, or repulsion (or assign “Factors Influencing Negative Sexual Attitudes” in the *Adult Psychotherapy Homework Planner* by Jongsma).

2. Report any signs of depression; participate in treatment of depressive feelings that may be causing sexual difficulties. (4, 5)
3. Honestly report substance abuse and cooperate with recommendations by the therapist for addressing it. (6)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)
4. Assess the role of depression in possibly causing the client's sexual dysfunction and treat if depression appears causal (see the Unipolar Depression chapter in this *Planner*).
5. Refer the client for antidepressant medication prescription to alleviate depression that underlies the sexual dysfunction.
6. Explore the client's use or abuse of mood-altering substances and their effect on sexual functioning; refer him for focused substance abuse counseling, if indicated.
7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently

defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.

10. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 11. Assess the quality of the relationship including couple satisfaction, distress, attraction, communication, and sexual repertoire toward making a decision to focus treatment on sexual problems or more broadly on the relationship (or assign “Positive and Negative Contributions to the Relationship: Mine and Yours” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 12. If relationship problem issues go beyond sexual dysfunction, conduct sex therapy in the context of couples therapy (see the Intimate Relationship Conflicts chapter in this *Planner*).
 13. Refer the client to a physician for a complete exam to rule out any organic or medication related basis for the sexual dysfunction (e.g., vascular, endocrine, medications). ▽
5. Honestly and openly discuss the quality of the relationship including conflicts, unfulfilled needs, and anger. (11, 12)
 6. Cooperate with a physician’s complete examination and follow through on any treatment recommendations. (13, 14)

- ▽ 7. Verbalize an understanding of the role that physical disease or medication has on sexual dysfunction. (15)
- ▽ 8. Take medication for impotence as ordered and report as to effectiveness and side effects. (16)
- ▽ 9. Participate in sex therapy with a partner or individually if the partner is not available. (17, 18)
- ▽ 10. Verbalize an understanding of normal sexual functioning and contributors to sexual dysfunction. (19, 20)
- ▽ 11. Demonstrate healthy acceptance by freely discussing accurate knowledge of sexual functioning. (21, 22) ▽
- 14. Encourage the client to follow physician's recommendations regarding treatment of a diagnosed medical condition or use of medication that may be causing the sexual problem. ▽
- 15. Discuss the contributory role that a diagnosed medical condition or medication use may be having on the client's sexual functioning. ▽
- 16. Refer the client to a physician for an evaluation regarding a prescription of medication to overcome impotence (e.g., Viagra). ▽
- 17. Encourage couples sex therapy or treat individually if a partner is not available (see *Enhancing Sexuality* by Wincze). ▽
- 18. Direct conjoint sessions with the client and his partner that focus on conflict resolution, expression of feelings, and sex education. ▽
- 19. Educate the client and partner about normal sexual functioning, sexual dysfunction, and cognitive, emotional, behavioral, and interpersonal factors that contribute to function or dysfunction. ▽
- 20. Assign the client to read books (e.g., *Sexual Awareness* by McCarthy and McCarthy; *The Gift of Sex* by Penner and Penner; *The New Male Sexuality* by Zilbergeld) that provide accurate sexual information and/or outline sexual practices that disinhibit and reinforce sexual sensate focus. ▽
- 21. Desensitize and educate the couple by encouraging them to talk freely and respectfully regarding sexual body parts, sexual thoughts, feelings, attitudes, and behaviors. ▽

12. Discuss low self-esteem issues that impede sexual functioning and verbalize a positive self-image. (23)
13. Verbalize a positive body image. (24, 25)
14. Communicate feelings of threat to partner that are based on perception of partner being too sexually aggressive or too critical. (26)
- ▽ 15. Identify challenge, and replace self-defeating thoughts and beliefs with positive, reality-based thoughts and beliefs. (27, 28, 29)
22. Reinforce the couple for talking freely, knowledgeably, and positively regarding sexual thoughts, feelings, and behavior. ▽
23. Explore the client's fears of inadequacy as a sexual partner that led to sexual avoidance; encourage realistic, positive thoughts regarding self as a sexual partner (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
24. Assign the client to list assets of his body; confront unrealistic distortions and critical comments (or assign "Study Your Body—Clothed and Unclothed" in the *Adult Psychotherapy Homework Planner* by Jongsma).
25. Explore the client's feelings regarding his body image, focusing on causes for negativism.
26. Explore the client's feelings of threat brought on by the perception of his partner as being too sexually aggressive or too critical of his sexual performance.
27. Probe automatic thoughts that trigger the client's negative emotions such as fear, shame, anger, or grief before, during, and after sexual activity. ▽
28. Train the client in healthy alternative thoughts that will mediate pleasure, relaxation, and disinhibition (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
29. Use cognitive therapy techniques to help the client counter

- self-defeating thoughts; identify and challenge self-talk, attentional focus (e.g., spectating), misinformation, and beliefs that perpetuate the dysfunction and replace with those facilitative of sexual functioning. ▽
16. List conditions and factors that positively affect sexual arousal, such as setting, time of day, or atmosphere. (30)
 - ▽ 17. Practice directed masturbation and sensate focus exercises alone and with partner and share feelings associated with activity. (31, 32)
 - ▽ 18. Participate in graduated exposure (desensitization) to sexual exercises that have gradually increasing anxiety attached to them. (33, 34)
 30. Assign the couple to list conditions and factors that positively affect their sexual arousal; process the list toward creating an environment conducive to sexual arousal.
 31. Assign the client body exploration and awareness exercises that reduce inhibition and desensitize him to sexual aversion. ▽
 32. Direct the client in masturbatory exercises designed to maximize arousal; assign the client graduated steps of sexual pleasuring exercises with partner that reduce his performance anxiety and focus on experiencing bodily arousal sensations (or assign “Journaling the Response to Nondemand, Sexual Pleasuring [Sensate Focus]” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
 33. Direct and assist the client in construction of a hierarchy of anxiety-producing sexual situations associated with performance anxiety. ▽
 34. Select initial in vivo or imaginal exposures that have a high likelihood of being a successful experience for the client and instruct him on attentional strategies (e.g., focus on partner, avoid spectating); review with the client and/or couple, moving up the hierarchy until associated anxiety has waned (or assign “Gradually

- Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
19. Engage in more assertive behaviors that allow for sharing sexual needs, feelings, and desires, behaving more sensuously, and expressing pleasure. (35, 36)
 20. Implement new coital positions and settings for sexual activity that enhance pleasure and satisfaction. (37, 38)
 - ▽^{EB} 21. Male partner implement masturbation prior to intercourse and/or the squeeze technique during sexual intercourse and report on success in slowing premature ejaculation. (39)
 35. Give the client permission for less inhibited, less constricted sexual behavior by assigning body-pleasuring exercises with partner.
 36. Encourage the client to gradually explore the role of being more sexually assertive, sensuously provocative, and freely uninhibited in sexual play with partner.
 37. Assign the client to read books (e.g., *Sexual Awareness* by McCarthy and McCarthy; *The Gift of Sex* by Penner and Penner; *In the Mood, Again: A Couple's Guide to Reawakening Sexual Desire* by Cervenka; *The Joy of Sex* by Comfort) that outline sexual practices that disinhibit and allow for sexual experimentation.
 38. Suggest experimentation with coital positions and settings for sexual play that may increase the client's feelings of security, arousal, and satisfaction.
 39. Prescribe pre-intercourse masturbation for the male partner to make use of the refractory period and/or instruct the client and partner in use of the squeeze technique to prevent premature ejaculation; use illustrations if needed (e.g., see *The Illustrated Manual of Sex Therapy* by Kaplan); process the procedure and feelings about it, providing corrective feedback toward successful use (recommend *Coping with Premature Ejaculation* by Metz and McCarthy).^{EB}▽

22. State an understanding of how religious training negatively influenced sexual thoughts, feelings, and behavior. (40, 41)
23. Verbalize a resolution of feelings regarding sexual trauma or abuse experiences. (42, 43)
24. Verbalize an understanding of the influence of childhood sex role models. (44)
25. Verbalize connection between previously failed intimate relationships and current fear. (45)
26. Discuss feelings surrounding a secret affair and make a termination decision regarding one of the relationships. (46, 47)
40. Explore the role of the client's religious training in reinforcing his feelings of guilt and shame surrounding his sexual behavior and thoughts; process toward the goal of change.
41. Assist the client in developing insight into the role of unhealthy sexual attitudes and experiences of childhood in the development of current adult dysfunction; press for a commitment to try to put negative attitudes and experiences in the past while making a behavioral effort to become free from those influences.
42. Probe the client's history for experiences of sexual trauma or abuse.
43. Process the client's emotions surrounding an emotional trauma in the sexual arena (see the Sexual Abuse Victim chapter in this *Planner*).
44. Explore sex role models the client has experienced in childhood or adolescence and how they have influenced the client's attitudes and behaviors.
45. Explore the client's fears surrounding intimate relationships and whether there is evidence of repeated failure in this area.
46. Explore for any secret sexual affairs that may account for the client's sexual dysfunction with his partner.
47. Process a decision regarding the termination of one of the relationships that is leading to internal conflict over the dishonesty and disloyalty to a partner.

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| <p>27. Openly acknowledge and discuss, if present, homosexual attraction. (48)</p> | <p>48. Explore for a homosexual interest that accounts for the client’s heterosexual disinterest (or assign “Journal of Sexual Thoughts, Fantasies, Conflicts” in the <i>Adult Psychotherapy Homework Planner</i> by Jongsma).</p> |
| <p>28. Resolve conflicts or develop coping strategies that reduce stress interfering with sexual interest or performance. (49)</p> | <p>49. Probe stress in areas such as work, extended family, and social relationships that distract the client from sexual desire or performance (see the Anxiety, Family Conflict, and Vocational Stress chapters in this <i>Planner</i>).</p> |

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	302.71	Hypoactive Sexual Desire Disorder
	302.79	Sexual Aversion Disorder
	302.72	Male Erectile Disorder
	302.74	Male Orgasmic Disorder
	302.76	Dyspareunia
	302.75	Premature Ejaculation
	608.89	Male Hypoactive Sexual Desire Disorder Due to Axis III Disorder
	607.84	Male Erectile Disorder Due to Axis III Disorder
	608.89	Male Dyspareunia Due to Axis III Disorder
	302.70	Sexual Dysfunction NOS
	995.53	Sexual Abuse of Child, Victim

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
302.71	F52.0	Male Hypoactive Sexual Desire Disorder
302.72	F52.21	Erectile Disorder
302.74	F52.32	Delayed Ejaculation
302.75	F52.4	Premature Ejaculation
302.70	F52.9	Unspecified Sexual Dysfunction
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

MEDICAL ISSUES

BEHAVIORAL DEFINITIONS

1. A diagnosis of a chronic illness that is not life-threatening, but necessitates changes in living.
2. A diagnosis of an acute, serious illness that is life-threatening.
3. A diagnosis of a chronic illness that eventually will lead to an early death.
4. Sad affect, social withdrawal, anxiety, loss of interest in activities, and low energy.
5. Suicidal ideation.
6. Denial of the seriousness of the medical condition.
7. Refusal to cooperate with recommended medical treatments.
8. A positive test for human immunodeficiency virus (HIV).
9. Acquired immune deficiency syndrome (AIDS).
10. Medical complications secondary to chemical dependence.
11. Psychological or behavioral factors that influence the course of the medical condition.
12. History of neglecting physical health.

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LONG-TERM GOALS

1. Medically stabilize physical condition.
2. Work through the grieving process and face with peace the reality of own death.

3. Accept emotional support from those who care, without pushing them away in anger.
4. Live life to the fullest extent possible, even though remaining time may be limited.
5. Cooperate with the medical treatment regimen without passive-aggressive or active resistance.
6. Become as knowledgeable as possible about the diagnosed condition and about living as normally as possible.
7. Reduce fear, anxiety, and worry associated with the medical condition.
8. Accept the illness, and adapt life to the necessary limitations.
9. Accept the role of psychological or behavioral factors in development of the medical condition and focus on resolution of these factors.

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SHORT-TERM OBJECTIVES

1. Describe history, symptoms, and treatment of the medical condition. (1, 2)

2. Disclose any history of or current involvement with substance abuse. (3, 4)

THERAPEUTIC INTERVENTIONS

1. In a collaborative fashion, develop a therapeutic alliance while gathering a history of the condition, including symptoms, client's reactions to the diagnosis, treatments of the condition, and prognosis.
2. With the client's informed consent, contact treating physician and family members for additional medical information regarding the client's diagnosis, treatment, and prognosis.
3. Explore and assess the role of chemical abuse on the client's medical condition.
4. Recommend that the client pursue treatment for his/her chemical

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well

dependence (see the Substance Use chapter in this *Planner*).

- as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Identify feelings associated with the medical condition. (9)
 5. Family members share with each other feelings that are triggered by the client's medical condition. (10)
 6. Identify the losses or limitations that have been experienced due to the medical condition. (11)
 7. Verbalize an increased understanding of the steps to grieving the losses brought on by the medical condition. (12, 13)
 8. Verbalize acceptance of the reality of the medical condition and the need for treatment. (14, 15, 16, 17)
 9. Assist the client in identifying, sorting through, and verbalizing the various feelings generated by his/her medical condition.
 10. Meet with family members to facilitate their clarifying and sharing possible feelings of guilt, anger, helplessness, and/or sibling attention jealousy associated with the client's medical condition.
 11. Ask the client to list the changes, losses, or limitations that have resulted from the medical condition (or assign "The Impact of My Illness" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 12. Educate the client on the stages of the grieving process and answer any questions that he/she may have.
 13. Suggest that the client read a book on grief and loss (e.g., *Good Grief* by Westberg; *How Can It Be Right When Everything Is All Wrong?* by Smedes; *When Bad Things Happen to Good People* by Kushner).
 14. Gently confront the client's denial of the seriousness of his/her condition and need for compliance with medical treatment procedures; reinforce the client's acceptance of his/her medical condition and compliance with treatment.
 15. Explore and process the client's fears associated with medical treatment, deterioration of physical

health, and subsequent death (or assign “How I Feel About My Medical Treatment” in the *Adult Psychotherapy Homework Planner* by Jongsma).

- ▼ 9. Commit to learning and implementing a proactive approach to managing personal stresses introduced by the medical condition/diagnosis. (18)
- ▼ 10. Journal thoughts, feelings, actions, and circumstances related to stressful reactions. (19)
- ▼ 11. Verbalize an understanding of the medical condition/diagnosis and managing the stress it can create. (20, 21)
16. Normalize the client’s feelings of grief, sadness, or anxiety associated with medical condition; encourage verbal expression of these emotions to significant others and medical personnel.
17. Assess the client for and treat his/her depression and anxiety (see the Unipolar Depression and Anxiety chapters in this *Planner*).
18. Use a Stress Inoculation Training approach to help the client develop knowledge and skills for managing stressful reactions to the medical condition/diagnosis; begin by using results of the assessment to identify the client’s stressful reactions, identify internal and external triggers of the reactions, as well as any current coping “strengths” (see *Stress Inoculation Training* by Meichenbaum). ▼
19. Ask the client to self-monitor and collect data that identifies both internal and external triggers for his/her stressful reactions, as well as coping “strengths.” ▼
20. Collaboratively teach a conceptualization of stress that highlights the different “phases” of stress reactions including: anticipating, management/coping, handling feelings generated by the stress, and reflecting on one’s coping efforts (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay); provide

accurate information about the medical condition and stress management, correcting misinformation and debunking any myths the client may have (e.g., venting negative emotions makes them go away). ▽

- 21. Refer the client and his/her family to reading material and reliable Internet resources for accurate information regarding the medical condition and the effect stress may have on the condition (consider assigning “Pain and Stress Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
 - 22. Assist the client in developing a tailored coping action plan for preventing and/or managing identified stressful reactions using skills such as relaxation, exercise, cognitive reframing, and problem-solving. ▽
 - 23. Conduct skills training, building upon effective coping strategies the client possesses, and teaching new skills tailored to the specific stressor. ▽
 - 24. Train problem-focused personal and interpersonal coping skills (e.g., problem-solving, communication, conflict resolution, accessing social supports). ▽
 - 25. Train emotionally focused coping skills (e.g., calming skills, perspective taking, emotional regulation, cognitive reframing). ▽
 - 26. Encourage skill development by having the client rehearse and practice coping skills in session through imaginal and/or behavioral rehearsal. ▽
- ▽ 12. Work with therapist to develop a plan for coping with stress. (22)
 - ▽ 13. Learn and implement skills for managing stress. (23, 24, 25)
 - ▽ 14. Demonstrate mastery of coping skills by applying them to daily life situations. (26, 27, 28)

- 27. Facilitate generalization of skills into everyday life by assigning homework (e.g., “Plan Before Acting” or “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma) in which the patient applies coping skills in graduating more demanding stressful situations; review, reinforcing success and problem-solving obstacles toward effective use of skills. ^{EB}▼
 - 28. Help the client internalize his/her new skill set and build self-efficacy by ensuring that the client “takes credit” for improvement and makes self-attributions for change. ^{EB}▼
 - 29. Teach the client relapse prevention skills including distinguishing between a lapse and relapse, identifying and rehearsing the management of high-risk situations using skills learned in therapy, building a less stressful lifestyle, and periodically attending “booster” sessions of therapy. ^{EB}▼
 - 30. Where appropriate, include significant others in the intervention plan to help create a reinforcing social system and social support. ^{EB}▼
 - 2. With the client’s informed consent, contact treating physician and family members for additional medical information regarding the client’s diagnosis, treatment, and prognosis.
 - 31. Monitor and reinforce the client’s compliance with the medical treatment regimen.
- 17. Comply with the medication regimen and necessary medical procedures, reporting any side effects or problems to physicians or therapists. (2, 31, 32, 33)
- 15. Learn and implement skills for preventing lapses back into more stressful reactions. (29)
 - 16. Share with significant others efforts to adapt successfully to the medical condition/ diagnosis. (30)

18. Engage in social, productive, and recreational activities that are possible in spite of medical condition. (34, 35)
19. Engage in faith-based activities as a source of comfort and hope. (36)
20. Attend a support group of others diagnosed with a similar illness. (37)
21. Partner and family members attend a support group. (38)
22. Implement positive imagery as a means of triggering peace of mind and reducing tension. (39, 40)
32. Explore and address the client's misconceptions, fears, and situational factors that interfere with medical treatment compliance (or assign "How I Feel About My Medical Treatment" in the *Adult Psychotherapy Homework Planner* by Jongsma).
33. Confront any manipulative, passive-aggressive, and denial mechanisms that block the client's compliance with the medical treatment regimen.
34. Sort out with the client activities that he/she can still enjoy either alone or with others (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma).
35. Solicit a commitment from the client to increase his/her activity level by engaging in enjoyable and challenging activities; reinforce such engagement.
36. Encourage the client to rely upon his/her spiritual faith promises, activities (e.g., prayer, meditation, worship, music), and fellowship as sources of support.
37. Refer the client to a support group of others living with a similar medical condition.
38. Refer family members to a community-based support group associated with the client's medical condition.
39. Teach the client the use of positive, relaxing, healing imagery to reduce stress and promote peace of mind.

23. Identify the coping skills and sources of emotional support that have been beneficial in the past. (41, 42)
24. Client's partner and family members verbalize their fears regarding the client's severely disabled life or possible death. (43)
25. Acknowledge any high-risk behaviors associated with sexually transmitted disease (STD). (44)
26. Accept the presence of an STD or HIV and follow through with medical treatment. (45, 46)
40. Encourage the client to rely on faith-based promises of God's love, presence, caring, and support to bring peace of mind.
41. Probe and evaluate the client's and family members' resources of emotional support and coping skills that have been beneficial in the past (or assign "Past Successful Anxiety Coping" in the *Adult Psychotherapy Homework Planner* by Jongsma).
42. Encourage the client and his/her family members to reach out for support from church leaders, extended family, hospital social services, community support groups, and God.
43. Draw out from the client's partner and family members their unspoken fears about his/her possible death; empathize with their feelings of panic, helpless frustration, and anxiety; if appropriate, reassure them of God's presence as the giver and supporter of life.
44. Assess the client's behavior for the presence of high-risk behaviors (e.g., IV drug use, unprotected sex, gay lifestyle, promiscuity) related to STD and HIV.
45. Refer the client to public health or a physician for STD and/or HIV testing, education, and treatment.
46. Encourage and monitor the client's follow-through on pursuing medical treatment for STD and HIV at a specialized treatment program, if necessary.

- 27. Identify sources of emotional distress that could have a negative impact on physical health. (47, 48)
- 47. Teach the client how lifestyle and emotional distress can have negative impacts on medical condition; review his/her lifestyle and emotional status to identify negative factors for physical health.
- 48. Assign the client to make a list of lifestyle changes he/she could make to help maintain physical health; process list.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:


Axis I:	316	Psychological Symptoms Affecting Axis III Disorder
	309.0	Adjustment Disorder With Depressed Mood
	309.24	Adjustment Disorder With Anxiety
	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
	309.3	Adjustment Disorder With Disturbance of Conduct
	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
	309.9	Adjustment Disorder Unspecified
	296.xx	Major Depressive Disorder
	311	Depressive Disorder NOS
	300.02	Generalized Anxiety Disorder
	301.01	Panic Disorder Without Agoraphobia
	301.21	Panic Disorder With Agoraphobia
	309.81	Posttraumatic Stress Disorder

	300.00	Anxiety Disorder NOS
	V71.09	No Diagnosis or Condition on Axis I
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Axis II:	799.9	Diagnosis Deferred
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
316	F54	Psychological Factors Affecting Other Medical Conditions
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.24	F43.22	Adjustment Disorder, With Anxiety
309.28	F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
309.4	F43.25	Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
311	F32.9	Unspecified Depressive Disorder
311	F32.8	Other Specified Depressive Disorder
300.02	F41.1	Generalized Anxiety Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

BEHAVIORAL DEFINITIONS

1. Intrusive, recurrent, and unwanted thoughts, images, or impulses that distress and/or interfere with the client's daily routine, job performance, or social relationships.
2. Failed attempts to ignore or control these thoughts, images, or impulses or neutralize them with other thoughts and actions.
3. Recognition that obsessive thoughts are a product of his/her own mind.
4. Repetitive and/or excessive mental or behavioral actions are done to neutralize or prevent discomfort or some dreaded outcome.
5. Recognition of repetitive thoughts and/or behaviors as being excessive and unreasonable, not realistic worries about life's problems.

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LONG-TERM GOALS

1. Reduce the frequency, intensity, and duration of obsessions and/or compulsions.
2. Reduce time involved with or interference from obsessions and compulsions.
3. Function daily at a consistent level with minimal interference from obsessions and compulsions.

4. Resolve key life conflicts and the emotional stress that fuels obsessive-compulsive behavior patterns.
5. Let go of key thoughts, beliefs, and past life events in order to maximize time free from obsessions and compulsions.
6. Accept the presence of obsessive thoughts without acting on them and commit to a value-driven life.

SHORT-TERM OBJECTIVES

1. Describe the history and nature of obsessions and compulsions. (1, 2)

2. Obtain a complete medical evaluation to rule out medical and substance-related causes for anxiety symptoms. (3, 4)

3. Complete psychological tests designed to assess and track the nature and severity of obsessions and compulsions. (5)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the frequency, intensity, duration, and history of the client's obsessions and compulsions (consider using a structured interview such as *The Anxiety Disorders Interview Schedule-Adult Version*).
3. Refer the client to a general physician for a complete medical examination to rule out medical or substance-related etiology for the anxiety.
4. Assist the client in following up on the recommendations from a physical evaluation, including medications, lab work, or specialty assessments.
5. Administer an objective measure of OCD to further assess its depth and breadth (e.g., *The Yale-Brown Obsessive-Compulsive Scale*;

- Obsessive-Compulsive Inventory-Revised*); readminister as indicated to assess treatment progress.
4. Disclose any history of substance use that may contribute to and complicate the treatment of OCD. (6)
 5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)
 6. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
 7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
 8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the

behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

- ▼ 6. Cooperate with an evaluation by a physician for psychotropic medication. (11, 12)
- ▼ 7. Keep a daily journal of obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken. (13)
- ▼ 8. Verbalize an accurate understanding of OCD, how it develops, and how it is maintained. (14)
- ▼ 9. Verbalize an understanding of the treatment rationale for OCD. (15, 16)
- 11. Arrange for an evaluation for a prescription of psychotropic medications (e.g., serotonergic medications). ▼
- 12. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. ▼
- 13. Ask the client to self-monitor obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken; routinely process the data to facilitate the accomplishment of therapeutic objectives (or assign “Analyze the Probability of a Feared Event” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼
- 14. Convey a biopsychosocial model for the development and maintenance of OCD highlighting the role of unwarranted fear and avoidance in its maintenance (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa). ▼
- 15. Provide a rationale for treatment to the client, discussing how treatment serves as an arena to desensitize learned fear, reality-test obsessional fears and underlying

beliefs, and build confidence in managing fears without compulsions (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa).^{EB}▽

16. Assign the client to read psychoeducational chapters of books or treatment manuals or consult other recommended sources for information on the rationale for exposure and ritual prevention therapy and/or cognitive restructuring for OCD (e.g., *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; *Getting Over OCD* by Abramowitz; *The OCD Workbook: Your Guide to Breaking Free from Obsessive-Compulsive Disorder* by Hyman and Pedrick).^{EB}▽
 17. Explore the client's biased schema and self-talk that mediate his/her obsessional fears and compulsions; assist him/her in generating thoughts that correct for the biases; use rational disputation and behavioral experiments to test fearful versus alternative predictions (see "Obsessive-Compulsive Disorder" by Salkovskis and Kirk).^{EB}▽
 18. Assign the client a homework exercise in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests though behavioral experiments (or assign "Journal and Replace Self-Defeating Thoughts" or "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.^{EB}▽
- ▽^{EB} 10. Identify and replace biased, fearful self-talk and beliefs. (17, 18)

- ▽^{EB} 11. Participate in imaginal or in vivo exposure to feared internal and/or external cues. (19, 20, 21, 22)
19. Assess the nature of any internal cues (thoughts, images, and impulses) and external cues (e.g., persons, objects, and situations) that precipitate the client's obsessions and compulsions. ▽^{EB}
20. Assist the client in the construction of hierarchies of feared internal and external fear cues. ▽^{EB}
21. Conduct exposure (imaginal and/or in vivo) to the internal and/or external OCD cues; begin with exposures that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa; or *Understanding and Treating Obsessive-Compulsive Disorder* by Abramowitz). ▽^{EB}
22. Assign the client homework exercises in which he/she repeats the exposure to the internal and/or external OCD cues, using response prevention and restructured cognitions, and records responses (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during subsequent sessions, reinforcing success, problem-solving obstacles, and providing corrective feedback toward improvement (see *Mastery of Obsessive-Compulsive Disorder* by Kozak and Foa). ▽^{EB}
- ▽^{EB} 12. Verbalize an understanding of relapse prevention. (23, 24)
23. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it. ▽^{EB}

- ▽ 13. Identify situations at risk for a lapse and strategies for managing these risk situations. (25, 26, 27, 28)
24. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of thinking, feeling and behaving that is characteristic of OCD. ▽
25. Identify high-risk situations and rehearse the management of future situations or circumstances in which lapses could occur. ▽
26. Instruct the client to routinely use strategies learned in therapy (e.g., continued everyday exposure, cognitive restructuring, problem-solving), building them into his/her life as much as possible. ▽
27. Develop a “coping card” or other reminder on which coping strategies and other helpful information can be kept and consulted by the client as needed (e.g., steps in problem-solving, positive coping statements, other strategies that were helpful to the client during therapy). ▽
28. Schedule periodic maintenance or “booster” sessions to help the client maintain therapeutic gains and problem-solve challenges. ▽
14. Participate in Acceptance and Commitment Therapy (ACT) for OCD. (29, 30, 31, 32)
29. Use an ACT approach to OCD to help the client accept and openly experience obsessive thoughts, images, and impulses without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

30. Teach mindfulness meditation to help the client recognize the negative thought processes associated with OCD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
31. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into in everyday life.
32. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
15. Identify and discuss unresolved life conflicts. (33, 34)
33. Explore the client's life circumstances to help identify key unresolved conflicts that may underlie OCD.
34. Read with the client the fable "The Friendly Forest" or "Round in Circles" from *Friedman's Fables* by Friedman, and then process using discussion questions.
16. Verbalize and clarify feelings connected to key life conflicts. (35, 36)
35. Encourage, support, and assist the client in identifying and expressing feelings related to key unresolved life issues.
36. Assess for secondary gains the client may be receiving by remaining disordered with OCD (e.g., attention, care-receiving, avoidance of activity); directly address gains, if evident.

17. Accept or work to resolve identified life conflicts. (37)
18. Gain insight into how childhood experiences might influence current struggles with OCD and take appropriate actions. (38)
19. Implement the Ericksonian task designed to interfere with OCD. (39)
20. Engage in a strategic ordeal to overcome OCD impulses. (40)
21. Develop and implement a daily ritual that interrupts the current pattern of compulsions. (41)
37. Explore the resolution of identified interpersonal or other identified life conflicts; assist the client with acceptance of those that cannot be changed or use a conflict-resolution approach to address those that can.
38. Use an insight-oriented approach to explore how current obsessive themes (e.g., cleanliness, symmetry, aggressive impulses) may be related to unresolved developmental conflicts (e.g., psychosexual, interpersonal); process toward the goal of insight and change.
39. Develop and assign an Ericksonian task (see *Ericksonian Approaches* by Battino and South) that is consistent with the theme of the client's obsession or compulsion (i.e., "symptom as task"); process the results with the client. (e.g., if obsessed with a loss, give the client the task to visit, send a card, or bring flowers to someone who has lost someone).
40. Create and sell a strategic ordeal that offers a guaranteed cure to the client for the obsession or compulsion. (Note at the beginning of the therapy that Haley emphasizes that the "cure" offers an intervention to achieve a goal and is not a promise to cure the client; see *Ordeal Therapy* by Haley).
41. Help the client create and implement a ritual (e.g., find a job that the client finds necessary but very unpleasant, and have him/her do this job each time he/she finds thoughts becoming obsessive); follow up with the client on the outcome of its implementation and make necessary adjustments.

DIAGNOSTIC SUGGESTIONS


Using DSM-IV/ICD-9-CM:

Axis I:	300.3	Obsessive-Compulsive Disorder
	300.00	Anxiety Disorder NOS
	296.xx	Major Depressive Disorder
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Axis II:	301.4	Obsessive-Compulsive Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.3	F42	Obsessive-Compulsive Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.4	F60.5	Obsessive-Compulsive Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and DSM-5 Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

PANIC/AGORAPHOBIA

BEHAVIORAL DEFINITIONS

1. Complains of unexpected, sudden, debilitating panic symptoms (e.g., shallow breathing, sweating, heart racing or pounding, dizziness, depersonalization or derealization, trembling, chest tightness, fear of dying or losing control, nausea) that have occurred repeatedly, resulting in persisting concern about having additional attacks.
2. Demonstrates marked avoidance of activities or environments due to fear of triggering intense panic symptoms, resulting in interference with normal routine.
3. Demonstrates marked fear and avoidance of bodily sensations associated with panic attacks, resulting in interference with normal routine.
4. Has to have a “safe person” accompany him/her to be able to do certain activities (e.g., travel, shop).
5. Increasingly isolates self due to fear of traveling or leaving a “safe environment,” such as home.
6. Avoids environments from which escape is not readily available (e.g., public transportation, in large groups of people, malls or big stores).
7. Displays no evidence of agoraphobia.

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LONG-TERM GOALS

1. Reduce the frequency, intensity, and duration of panic attacks.
2. Reduce the fear that panic symptoms will recur without the ability to manage them.
3. Reduce the fear of triggering panic and eliminate avoidance of activities and environments thought to trigger panic.
4. Increase comfort in freely leaving home and being in a public environment.
5. Learn to accept occasional panic symptoms and fearful thoughts without it affecting actions.

SHORT-TERM OBJECTIVES

1. Describe the history and nature of the panic symptoms. (1, 2)

2. Complete psychological tests designed to assess the depth and breadth of fear and avoidance. (3)

3. Disclose any history of substance use that may contribute to and complicate

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the client's frequency, intensity, duration, and history of panic symptoms and the type and severity of avoidance (e.g., *The Anxiety Disorders Interview Schedule-Adult Version*).
3. Administer surveys to assess the depth and breadth of fears and avoidance (e.g., *The Mobility Inventory for Agoraphobia*; *The Anxiety Sensitivity Index*); discuss results with client; readminister as indicated to assess treatment progress.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation

the treatment of panic or agoraphobia. (4)

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well

recommends it (see the Substance Use chapter in this *Planner*).

- as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼ 5. Cooperate with an evaluation by a physician for psychotropic medication. (9)
 - ▼ 6. Take prescribed psychotropic medications consistently. (10)
 - ▼ 7. Complete a daily journal of experiences with panic and agoraphobia. (11)
 - ▼ 8. Verbalize an accurate understanding of panic attacks and agoraphobia and their treatment. (12, 13)
 9. Arrange for an evaluation for a prescription of psychotropic medications to alleviate the client's symptoms (e.g., serotonergic medication). ▼
 10. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. ▼
 11. Ask the client to self-monitor panic and avoidance including cues, level of distress, symptoms, thoughts, and behaviors (or assign "Monitoring My Panic Attack Experiences" in the *Adult Psychotherapy Homework Planner* by Jongsma); use data throughout therapy to support therapeutic interventions (e.g., psychoeducation, cognitive restructuring). ▼
 12. Discuss how panic attacks are "false alarms" of danger, not medically dangerous, not a sign of weakness or craziness, common but often lead to unnecessary fear and avoidance; correct myths and misconceptions about panic symptoms (e.g., going crazy, dying, losing control) that contribute to fear and avoidance. ▼
 13. Assign the client to read psychoeducational chapters of books or treatment manuals on panic disorders and agoraphobia (e.g., *Mastery of Your Anxiety and*

Panic—Workbook by Barlow and Craske; *Don't Panic: Taking Control of Anxiety Attacks* by Wilson; *Living with Fear* by Marks; *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by McKay, Davis, and Fanning).^{EB}

- ▼^{EB} 9. Verbalize an understanding of the rationale for treatment of panic. (14)
 - ▼^{EB} 10. Implement calming and coping strategies to reduce overall anxiety and to cope with the experience of panic. (15, 16, 17)
- 14. Discuss how exposure serves as an arena to desensitize learned fear, build confidence, and feel safer by building a new history of successful experiences.^{EB}
- 15. Teach the client progressive muscle relaxation as a daily exercise for general relaxation and train him/her in the use of coping strategies (e.g., staying focused on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, positive self-talk) to manage symptom attacks.^{EB}
- 16. Assign capnometry-assisted respiratory training (CART) to teach the client, by providing CO₂ level biofeedback, how to gain control over dysfunctional respiratory patterns and associated panic symptoms (e.g., lightheadedness, shortness of breath) through reducing hyperventilation and breathing more slowly and more shallow (see *Therapeutic Use of Ambulatory Capnography* by Meuret et al.).^{EB}
- 17. Teach the client cognitive coping strategies such as encouraging positive self-talk and/or keeping focused on external stimuli and behavioral responsibilities during panic rather than being preoccupied with internal focus on feared physiological changes.^{EB}

- ▽ 11. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (18, 19)
18. Explore the client's schema and self-talk that mediate his/her fear response, identify and challenge biases; assist him/her in replacing the distorted messages with alternatives that correct for the biases such as overestimating the likelihood of catastrophic outcomes and underestimating one's ability to cope with panic symptoms. ▽
19. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); test fear-based predictions against alternatives using behavioral experiments; review; reinforce success, problem-solve obstacles toward accomplishing objective (see *10 Simple Solutions to Panic* by Antony and McCabe; *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske). ▽
- ▽ 12. Participate in gradual exposure to feared physical sensations until they are no longer frightening to experience. (20, 21)
20. Teach the client a sensation exposure technique in which he/she generates feared physical sensations through exercise (e.g., breathes rapidly until slightly lightheaded, spins in chair briefly until slightly dizzy), then records and allows sensations and anxiety associated with them to calm (e.g., using cognitive and/or somatic coping strategies; repeat exercise until anxiety associated with physical sensations wanes (see *10 Simple Solutions to Panic* by Antony and McCabe; *Mastery of*

Your Anxiety and Panic—Therapist Guide by Craske and Barlow).^{EB}▽

- ▽^{EB} 13. Undergo gradual repeated exposure to feared or avoided situations. (22, 23, 24)
21. Assign the client a homework exercise in which he/she does sensation exposures and records (e.g., *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske; *10 Simple Solutions to Panic* by Antony and McCabe); review; reinforce success, problem-solve obstacles toward accomplishing objective.^{EB}▽
22. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with agoraphobia in which a symptom attack and its negative consequences are feared.^{EB}▽
23. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms and rehearse the plan in imagination.^{EB}▽
24. Assign the client a homework exercise in which he/she does situational exposures and records responses (e.g., “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma; *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske; *10 Simple Solutions to Panic* by Antony and McCabe); review; reinforce success, problem-solve obstacles toward accomplishing objective.^{EB}▽
- ▽^{EB} 14. Implement relapse prevention strategies for managing possible future anxiety symptoms. (25, 26, 27, 28, 29)
25. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of

symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns. ^{EB}▼

26. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. ^{EB}▼
27. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into his/her life as much as possible. ^{EB}▼
28. Develop a “coping card” on which coping strategies and other important information (e.g., “Pace your breathing,” “Focus on the task at hand,” “You can manage it,” and “It will go away”) are recorded for the client’s later use. ^{EB}▼
29. Schedule a “booster session” for the client for 1 to 3 months after therapy ends to track progress, reinforce gains, and problem-solve barriers. ^{EB}▼
15. Participate in Acceptance and Commitment Therapy (ACT) for panic disorder. (30, 31, 32, 33)
30. Use an ACT approach to help the client accept and openly experience anxious thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).
31. Teach mindfulness meditation to help the client recognize the negative thought processes associated with panic and change his/her relationship with these thoughts by accepting thoughts,

- images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zablat-Zinn).
16. Work through developmental conflicts that may be influencing current struggles with fear and avoidance and take appropriate actions. (34)
 17. Identify and discuss unresolved life conflicts. (35)
 18. Verbalize and clarify feelings connected to key life conflicts. (36, 37)
 32. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.
 33. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
 34. Use an insight-oriented approach to explore how psychodynamic conflicts (e.g., separation/autonomy; anger recognition, management, and coping) may be manifesting as fear and avoidance; address transference; work through separation and anger themes during therapy and upon termination toward developing a new ability to manage separations and autonomy.
 35. Explore the client's life circumstances to help identify key unresolved conflicts that may underlie panic disorder.
 36. Encourage, support, and assist the client in identifying and expressing feelings related to key unresolved life issues.
 37. Assess for secondary gains the client may be receiving by remaining disordered with panic and/or agoraphobia (e.g., attention, care-receiving, avoidance of activity); directly address gains, if evident.

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| <p>19. Accept or work to resolve identified life conflicts. (38)</p> | <p>38. Explore the resolution of identified interpersonal or other identified life conflicts; assist the client with acceptance of those that cannot be changed or use a conflict-resolution approach to address those that can.</p> |
| <p>20. Implement the Ericksonian task designed to face fear. (39)</p> | <p>39. Develop and assign an Ericksonian task (see <i>Ericksonian Approaches</i> by Battino and South) that is consistent with the theme of the client's fears (e.g., the client fears traveling past a certain boundary, so ask him/her to go to it, walk a certain number of steps past it, stop, allow anxiety to come and go, and repeat); process the results with the client</p> |
| <p>21. Commit self to not allowing the threat of panic symptoms to control decisions in life; take actions based on personal goals rather than fear and avoidance. (40)</p> | <p>40. Support the client in following through with work, family, and social activities rather than escaping or avoiding them to focus on panic symptoms.</p> |

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

<p>Axis I:</p>	<p>300.01 300.21 300.22 _____ _____</p>	<p>Panic Disorder Without Agoraphobia Panic Disorder With Agoraphobia Agoraphobia Without History of Panic Disorder _____ _____</p>
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.01	F41.0	Panic Disorder
300.22	F40.00	Agoraphobia
300.02	F41.1	Generalized Anxiety Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

PARANOID IDEATION

BEHAVIORAL DEFINITIONS

1. Extreme or consistent distrust of others generally or someone specifically, without sufficient basis.
2. Expectation of being exploited or harmed by others.
3. Misinterpretation of benign events as having threatening personal significance.
4. Hypersensitivity to hints of personal critical judgment by others.
5. Inclination to keep distance from others out of fear of being hurt or taken advantage of.
6. Tendency to be easily offended and quick to anger; defensiveness is common.
7. A pattern of being suspicious of the loyalty or fidelity of spouse or significant other without reason.
8. Level of mistrust is obsessional to the point of disrupting daily functioning.

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LONG-TERM GOALS

1. Show more trust in others by speaking positively of them and reporting comfort in socializing.
2. Interact with others without defensiveness or anger.
3. Verbalize trust of significant other and eliminate accusations of disloyalty.

4. Report reduced vigilance and suspicion around others as well as more relaxed, trusting, and open interaction.
5. Concentrate on important matters without interference from suspicious obsessions.
6. Function appropriately at work, in social activities, and in the community with only minimal interference from distrustful obsessions.

SHORT-TERM OBJECTIVES

1. Demonstrate a level of trust with therapist by disclosing feelings and beliefs. (1, 2)

2. Identify those people or agencies that are distrusted and why. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Actively build level of trust with the client by explicitly acknowledging the client's difficulty, allowing him/her to lead discussions and establishing one's role as the therapist, whose interest in the client is strictly professional.
2. Use good eye contact, active listening, unconditional positive regard, and warm acceptance to help increase the client's ability to identify and express feelings; demonstrate a calm, tolerant demeanor in sessions to decrease the client's fears.
3. Assess the nature, extent, and severity of the client's paranoia, probing for delusional beliefs and conviction in them.
4. Explore the client's basis for fears; assess his/her degree of irrationality and ability to acknowledge that he/she is thinking irrationally.

3. Complete a psychological evaluation to assess the depth of paranoia. (5)
4. Disclose any history of substance use that may contribute to and complicate the treatment of paranoid ideation. (6)
5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)
5. Refer or conduct psychological and/or neuropsychological testing including assessment of a possible psychotic process (e.g., Minnesota Multiphasic Personality Inventory-2, NEO Personality Inventory-Revised, The Schedule for Nonadaptive and Adaptive Personality-2, give relevant feedback of results to the client.
6. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and

factors that could offer a better understanding of the client's behavior.

6. Comply with a medical evaluation to assess medical health. (11)
7. Comply with a psychiatric evaluation and take psychotropic medication as prescribed. (12, 13, 14)
8. Participate in a comprehensive rehabilitation program for the presenting problem. (15)
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
11. Refer the client to a physician for a medical evaluation to rule out a possible medical and/or substance-related etiology.
12. Assess the necessity for anti-psychotic medication and the client's willingness to explore the option.
13. Refer the client to a psychiatrist for a medication evaluation to assess the need for a psychotropic medication prescription.
14. Monitor the client's psychotropic medication prescription for compliance, effectiveness, and side effects; report to the prescribing physician and directly address noncompliance, if present.
15. Assess whether the client's paranoid ideation is occurring within a clinical syndrome (e.g., paranoid schizophrenia, delusional disorders), and if so, conduct or refer to an appropriate evidence-based treatment that is delivered as part of

- a comprehensive rehabilitation program (e.g., see the Psychoticism chapter in this *Planner*).
9. Identify feelings associated with the distrust. (16, 17, 18)
 10. Identify core belief that others are untrustworthy and malicious. (19, 20)
 11. Explore the positive and negative impact of beliefs that others are untrustworthy and malicious. (21)
 12. Acknowledge other feelings that may underlie distrust of others. (22, 23)
 13. Acknowledge that the belief about others being threatening is based more on subjective
 16. Probe feelings that may underlie paranoia including inferiority, shame, humiliation, rejection.
 17. Explore historical sources of the client's feelings of vulnerability in family-of-origin experiences.
 18. Interpret the client's paranoia as a defense against his/her expressed feelings including inferiority, shame, humiliation, rejection.
 19. Explore the client's self-talk and maladaptive beliefs that underlie paranoia (e.g., people cannot be trusted, getting close to people will result in hurt).
 20. Review the client's social interactions to explore his/her distorted cognitive beliefs operative during interactions.
 21. Facilitate a cost-benefit analysis around the client's specific fears; or assign the client to complete a cost-benefit analysis exercise (see *The Feeling Good Handbook* by Burns); process the results toward continuing movement toward therapeutic goals.
 22. Assess for the client's ability to acknowledge that his/her thinking is maladaptive; work to improve acknowledgement.
 23. Assist the client in seeing the pattern of distrusting others as being related to his/her own fears of inadequacy.
 24. Assist the client in generating alternatives to distorted thoughts and beliefs that correct for the

interpretation than on objective data. (24, 25)

biases; use role reversal to allow the client to argue for and against biased and alternative beliefs toward facilitating cognitive restructuring.

14. Verbalize trust in significant other and feel relaxed when not in his/her presence. (26, 27)

25. Assign the client to test distorted and alternative beliefs through behavioral experiments in which both are converted to predictions and tested through homework exercises.

26. Conduct conjoint sessions to assess and reinforce the client's verbalizations of trust toward significant other.

27. Provide alternative explanations for significant other's behavior that counters the client's pattern of assumption of other's malicious intent.

15. Learn and implement skills that facilitate increased satisfying social interaction without fear or suspicion. (28, 29)

28. Encourage the client not to jump to conclusions about others but rather check out his/her beliefs regarding others by respectfully and assertively verifying conclusions with others.

29. Use instruction, role-playing, behavioral rehearsal, and role reversal to increase the client's empathy for others, his/her understanding of the impact that his/her distrustful defensive behavior has on others, and develop effective relevant social skills.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.23	Social Phobia
	310.1	Personality Change Due to Axis III Disorder
	295.30	Schizophrenia, Paranoid Type
	297.1	Delusional Disorder
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Axis II:	301.0	Paranoid Personality Disorder
	310.22	Schizotypal Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
310.1	F07.0	Personality Change Due to Another Medical Condition
295.30	F20.9	Schizophrenia
298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
297.1	F22	Delusional Disorder
298.8	F23	Brief Psychotic Disorder
295.4	F20.40	Schizophreniform Disorder
301.0	F60.0	Paranoid Personality Disorder
310.22	F21	Schizotypal Personality Disorder

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PARENTING

BEHAVIORAL DEFINITIONS

1. Expresses feelings of inadequacy in setting effective limits with their child.
2. Reports difficulty in managing the challenging problem behavior of their child.
3. Frequently struggles to control their emotional reactions to their child's misbehavior.
4. Exhibits increasing conflict between spouses over how to parent/discipline their child.
5. Displays deficits in parenting knowledge and skills.
6. Displays inconsistent parenting styles.
7. Demonstrates a pattern of lax supervision and inadequate limit-setting.
8. Regularly overindulges their child's wishes and demands.
9. Displays a pattern of harsh, rigid, and demeaning behavior toward their child.
10. Shows a pattern of physically and emotionally abusive parenting.
11. Lacks knowledge regarding reasonable expectations for a child's behavior at a given developmental level.
12. Have exhausted their ideas and resources in attempting to deal with their child's behavior.

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LONG-TERM GOALS

1. Achieve a level of competent, effective parenting.
2. Effectively manage challenging problem behavior of the child.
3. Reach a realistic view and approach to parenting, given the child's developmental level.
4. Terminate ineffective and/or abusive parenting and implement positive, effective techniques.
5. Strengthen the parental team by resolving marital conflicts.
6. Achieve a greater level of family connectedness.

SHORT-TERM OBJECTIVES

1. Identify major concerns regarding the child's misbehavior and the associated parenting approaches that have been tried. (1)
2. Describe any conflicts that result from the different approaches to parenting that each partner has. (2)
3. Parents and child cooperate with psychological testing designed to enhance understanding of the family. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Using empathy and normalization of the parents' struggles, conduct a clinical interview focused on pinpointing the nature and severity of the child's misbehavior; assess parenting styles used to respond to the child's misbehavior, and what triggers and reinforcements may be contributing to the behavior.
2. Assess the parents' consistency in their approach to the child and whether they have experienced conflicts between them over how to react to the child.
3. Administer psychological instruments designed to objectively assess parent-child relational conflict (e.g., the *Parenting Stress Index*; the *Parent-Child*

Relationship Inventory), traits of oppositional defiance or conduct disorder (e.g., *Adolescent Psychopathology Scale-Short Form [APS-SF]*; the *Millon Adolescent Clinical Inventory [MACI]*); discuss results with clients toward increasing understanding of the problems and engage in treatment; readminister as indicated to assess treatment progress.

4. Conduct or arrange for psychological testing to help in assessing for comorbid conditions (e.g., depression, ADHD) contributing to disruptive behavior problems; follow up accordingly with client and parents regarding treatment options; readminister as indicated to assess treatment progress.
4. Disclose any significant marital conflicts and work toward their resolution. (5, 6)
5. Analyze the data received from the parents about their relationship and parenting and establish or rule out the presence of superseding marital conflicts.
5. Disclose any history of substance use that may contribute to and complicate the treatment of parenting issues. (7)
6. Conduct or refer the parents to marital/relationship therapy to resolve the conflicts that are preventing them from being effective parents (see the *Intimate Relationship Conflicts* chapter in this *Planner*).
6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM*
7. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the *Substance Use* chapter in this *Planner*).
8. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into

diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)

the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
10. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
11. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

7. Cooperate with an evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (12)
8. Freely express feelings of frustration, helplessness, and inadequacy that each experiences in the parenting role. (13, 14, 15)
- ▽ 9. Verbalize a commitment to learning and using alternative ways to think about and manage anger and misbehavior. (16, 17)
12. Assess the client for the need for psychotropic medication to assist in control of anger and other misbehaviors; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.
13. Create a compassionate, empathetic environment where the parents become comfortable enough to let their guard down and express the frustrations of parenting.
14. Educate the parents on the full scope of parenting by using humor and normalization.
15. Help the parents reduce their unrealistic expectations of their parenting performance, identify parental strengths, and begin to build the confidence and effectiveness level of the parental team.
16. Assist the parent in re-conceptualizing anger as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out) that can be managed. ▽
17. Assist the parent in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved physical health, etc.); ask the client to agree to learn new ways to

- ▼^{EB} 10. Verbalize an understanding of the numerous key differences between boys and girls at different levels of development and adjust expectations and parenting practices accordingly. (18)
- ▼^{EB} 11. Verbalize an increased awareness and understanding of the unique issues and trials of parenting adolescents. (19, 20, 21)
- ▼^{EB} 12. Verbalize an understanding of the impact of their reaction on their child's behavior. (22, 23)
- conceptualize and manage anger and misbehavior. ▼^{EB}
18. Educate the parents on key developmental differences between boys and girls, such as rate of development, perspectives, impulse control, temperament, and how these influence the parenting process. ▼^{EB}
19. Educate the parents about the various biopsychosocial influences on adolescent behavior including biological changes, peer influences, self-concept, identity, and parenting styles. ▼^{EB}
20. Teach the parents the concept that adolescence is a time in which the parents need to “ride the adolescent rapids” (see *Positive Parenting for Teenagers: Empowering Your Teen and Yourself through Kind and Firm Parenting* by Nelson and Lott; *Turning Points* by Pittman; *Preparing for Adolescence: How to Survive the Coming Years of Change* by Dobson) until both survive. ▼^{EB}
21. Assist the parents in coping with the issues and reducing their fears regarding negative peer groups, negative peer influences, and losing their influence to these groups. ▼^{EB}
22. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive

change (e.g., *Parenting the Strong-Willed Child* by Forehand and Long).^{EB}▽

- ▽^{EB} 13. Learn and implement parenting practices that have demonstrated effectiveness. (24, 25, 26, 27)
23. Assign the parents to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise and clearly established rewards), use of calm clear direct instruction, time out, and other loss-of-privilege practices for problem behavior.^{EB}▽
24. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear direct instruction, time out and other loss-of-privilege practices for problem behavior, negotiation, and renegotiation—usually with older children and adolescents (see *Defiant Teens: A Clinician's Manual for Assessment and Family Intervention* by Barkley, Edwards, and Robin; *Defiant Children: A Clinician's Manual for Parent Training* by Barkley).^{EB}▽
25. Assign the parents home exercises in which they implement parenting skills and record results of implementation (or assign “Using Reinforcement Principles in Parenting” in the *Adult Psychotherapy Homework Planner* by

- Jongsma); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills. ▾
26. Ask the parents to read parent-training manuals consistent with the therapy (e.g., *Parents and Adolescents Living Together: The Basics* by Patterson and Forgatch; *Parents and Adolescents Living Together: Family Problem Solving* by Forgatch and Patterson; *The Kazdin Method for Parenting the Defiant Child* by Kazdin). ▾
 27. Refer parents to an *Incredible Years* program, a group parent training program that teaches positive child management practices and stress management techniques (see www.incredibleyears.com) ▾
 28. Use a Parent-Child Interaction Therapy approach involving Child-Directed Interaction in which parents engage their child in a play situation that the child directs as well as Parent Directed Interaction where parents are taught how to use specific behavior management techniques as they play with their child (see *Parent-Child Interaction Therapy* by McNeil and Humberg-Kigin). ▾
 29. Support, empower, monitor, and encourage the parents in implementing new strategies for parenting their child; reinforce successes; problem-solve obstacles toward consolidating a coordinated, consistent, and effective parenting style. ▾
 30. Use a Cognitive-Behavioral Therapy approach with older
- ▾ 14. Interact with children under the supervision of the therapist to improve parenting knowledge and skills and the quality of parent-child interactions. (28)
 - ▾ 15. Verbalize a sense of increased skill, effectiveness, and confidence in parenting. (29)
 - ▾ 16. Older children and adolescents learn and implement skills for

managing self and interactions with others. (30, 31)

children and adolescents using several techniques such as instruction, modeling, role-playing, feedback, and practice to teach the child how to manage his/her emotional reactions, manage interpersonal interactions, and problem-solving conflicts. ▽

- ▽ 17. Develop skills to talk openly and effectively with the children. (32, 33)
- 31. Use structured tasks involving games, stories, and other activities in session to develop personal and interpersonal skills, then carry them into real-life situations through homework exercises; review; reinforce successes; problem-solve obstacles toward integration into the child's life. ▽
- 32. Use instruction, modeling, and role-play to teach the parents how to communicate effectively with their child including use open-ended questions, active listening, and respectful assertive communication that encourage openness, sharing, and ongoing dialogue. ▽
- 33. Ask the parents to read material on parent-child communication (e.g., *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber and Mazlish; *Parent Effectiveness Training* by Gordon); help them implement the new communication style in daily dialogue with their children and to see the positive responses each child had to it. ▽
- 18. Parents expand repertoire of parenting options (34, 35)
- 34. Expand the parents' repertoire of intervention options by having them read material on parenting difficult children (e.g., *The Difficult Child* by Turecki and Tonner; *The Explosive Child* by Greene; *How to Handle a Hard-to-Handle Kid* by Edwards).

19. Identify unresolved childhood issues that affect parenting and work toward their resolution. (36, 37)
20. Partners express verbal support of each other in the parenting process. (38, 39)
21. Decrease outside pressures, demands, and distractions that drain energy and time from the family. (40, 41)
35. Support, empower, monitor, and encourage the parents in implementing new strategies for parenting their child, giving feedback and redirection as needed.
36. Explore each parent's story of his/her childhood to identify any unresolved issues that are present (e.g., abusive or neglectful parents, substance abuse by parents, etc.) and to identify how these issues are now affecting the ability to effectively parent.
37. Assist the parents in working through issues from their own childhood that are unresolved.
38. Assist the parental team in identifying areas of parenting weaknesses; help the parents improve their skills and boost their confidence and follow-through.
39. Help the parents identify and implement specific ways they can support each other as parents and in realizing the ways children work to keep the parents from cooperating in order to get their way (or assign "Learning to Parent as a Team" in the *Adult Psychotherapy Homework Planner* by Jongsma).
40. Give the parents permission to not involve their child and themselves in too numerous activities, organizations, or sports.
41. Ask the parents to provide a weekly schedule of their entire family's activities and then evaluate the schedule with them, looking for which activities are valuable and which can possibly be

- eliminated to create a more focused and relaxed time to parent.
22. Increase the gradual letting go of their adolescent in constructive, affirmative ways. (42)
 23. Parents and child report an increased feeling of connectedness between them. (43, 44)
 24. Verbalize an understanding of relapse prevention and the difference between a lapse and a relapse. (45, 46, 47)
 25. Learn and implement strategies to prevent relapse of disruptive behavior. (48, 49, 50)
 42. Guide the parents in identifying and implementing constructive, affirmative ways they can allow and support the healthy separation of their adolescent.
 43. Assist the parents in removing and resolving any barriers that prevent or limit connectedness between family members and in identifying activities that will promote connectedness (e.g., games, one-to-one time).
 44. Encourage the parents to see that just “hanging out at home” or being around/available is quality time.
 45. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.
 46. Discuss with the parent/child the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of conflict.
 47. Identify and rehearse with the parent/child the management of future situations or circumstances in which lapses could occur.
 48. Instruct the parent/child to routinely use strategies learned in therapy (e.g., parent training techniques, problem-solving, anger management), building them into his/her life as much as possible.
 49. Develop a “coping card” or other recording on which coping strategies and other important information can be kept (e.g., steps

in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

- 50. Schedule periodic maintenance or “booster” sessions to help the parent/child maintain therapeutic gains and problem-solve challenges.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:


Axis I:	309.3	Adjustment Disorder With Disturbance of Conduct
	309.4	Adjustment Disorder With Mixed Disturbances of Emotions and Conduct
	V61.21	Neglect of Child
	V61.20	Parent-Child Relational Problem
	V61.10	Partner Relational Problem
	V61.21	Physical Abuse of Child
	V61.21	Sexual Abuse of Child
	313.81	Oppositional Defiant Disorder
	312.9	Disruptive Behavior Disorder NOS
	312.8	Conduct Disorder, Adolescent-Onset Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.6	Dependent Personality Disorder
	301.81	Narcissistic Personality Disorder

799.9 Diagnosis Deferred
 V71.09 No Diagnosis on Axis II

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
309.4	F43.25	Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct
V61.21	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Neglect
V61.20	Z62.820	Parent-Child Relational Problem
V61.10	Z63.0	Relationship Distress with Spouse or Intimate Partner
V61.22	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Abuse
V61.22	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Sexual Abuse
313.81	F91.3	Oppositional Defiant Disorder
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
312.82	F91.2	Conduct Disorder, Adolescent-Onset Type
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
314.01	F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Presentation
301.7	F60.2	Antisocial Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

PHASE OF LIFE PROBLEMS

BEHAVIORAL DEFINITIONS

1. Difficulty adjusting to the accountability and interdependence of a new marriage.
2. Anxiety and depression related to the demands of being a new parent.
3. Grief related to children emancipating from the family (“empty nest stress”).
4. Restlessness and feelings of lost identity and meaning due to retirement.
5. Feelings of isolation, sadness, and boredom related to quitting employment to be a full-time homemaker and parent.
6. Frustration and anxiety related to providing oversight and caretaking to an aging, ailing, and dependent parent.

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LONG-TERM GOALS

1. Resolve conflicted feelings and adapt to the new life circumstances.
2. Reorient life view to recognize the advantages of the current situation.
3. Find satisfaction in serving, nurturing, and supporting significant others who are dependent and needy.
4. Balance life activities between consideration of others and development of own interests.

SHORT-TERM OBJECTIVES

1. Describe the circumstances of life that are contributing to stress, anxiety, or lack of fulfillment. (1, 2, 3)

2. Disclose any history of substance use that may contribute to and complicate the treatment of phase of life problems. (4)

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

THERAPEUTIC INTERVENTIONS

1. Explore the client’s current life circumstances that are causing frustration, anxiety, depression, or lack of fulfillment.

2. Assign the client to write a list of those circumstances that are causing concern and how or why each is contributing to his/her dissatisfaction (or assign “What Needs to Be Changed in My Life?” from the *Adult Psychotherapy Homework Planner* by Jongsma).

3. Assist the client in listing those desirable things that are missing from his/her life that could increase his/her sense of fulfillment.

4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

5. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the

“problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Identify values that guide life’s decisions and determine fulfillment. (9, 10)
9. Assist the client in clarifying and prioritizing his/her values (consider assigning “Developing Noncompetitive Values” from the *Adult Psychotherapy Homework Planner* by Jongsma).

5. Implement new activities that increase a sense of satisfaction. (11, 12)
6. Identify and implement changes that will reduce feelings of being overwhelmed by caretaking responsibilities. (13, 14)
7. Implement increased assertiveness to take control of conflicts. (15, 16, 17)
10. Assign the client to read books on values clarification (e.g., *Values Clarification* by Simon, Howe, and Kirschenbaum; *In Search of Values: 31 Strategies for Finding Out What Really Matters Most to You* by Simon); process the content and list values that he/she holds as important.
11. Develop a plan with the client to include activities that will increase his/her satisfaction, fulfill his/her values, and improve the quality of his/her life.
12. Review the client's attempts to modify his/her life to include self-satisfying activities; reinforce success and redirect for failure.
13. Brainstorm with the client possible sources of support or respite (e.g., parent support group, engaging spouse in more child care, respite care for elderly parent, sharing parent-care responsibilities with a sibling, utilizing home health-care resources, taking a parenting class) from the responsibilities that are overwhelming him/her.
14. Encourage the client to implement the changes that will reduce the burden of responsibility felt; monitor progress, reinforcing success and redirecting for failure.
15. Use role-playing, modeling, and behavior rehearsal to teach the client assertiveness skills that can be applied to reducing conflict or dissatisfaction.
16. Refer the client to an assertiveness training class.
17. Encourage the client to read books on assertiveness and boundary

setting (e.g., *The Assertiveness Workbook: How to Express Your Ideas and Stand Up for Yourself at Work and in Relationships* by Paterson; *Asserting Yourself* by Bower and Bower; *When I Say No, I Feel Guilty* by Smith; *Your Perfect Right* by Alberti and Emmons); process the content and its application to the client's daily life.

8. Apply problem-solving skills to current circumstances. (18, 19)
9. Increase communication with significant others regarding current life stress factors. (20, 21)
10. Identify five advantages of current life situation. (22)
18. Teach the client problem-resolution skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating outcome, and readjusting plan as necessary).
19. Use modeling and role-playing with the client to apply the problem-solving approach to his/her current circumstances (or assign "Applying Problem-Solving to Interpersonal Conflict" from the *Adult Psychotherapy Homework Planner* by Jongsma); encourage implementation of action plan, reinforcing success and redirecting for failure.
20. Teach the client communication skills (e.g., "I messages," active listening, eye contact) to apply to his/her current life stress factors.
21. Invite the client's partner and/or other family members for conjoint sessions to address the client's concerns; encourage open communication and group problem solving.
22. Assist the client in identifying at least five advantages to his/her

- current life circumstance that may have been overlooked or discounted (e.g., opportunity to make own decisions, opportunity for intimacy and sharing with a partner, a time for developing personal interests or meeting the needs of a significant other).
11. Implement changes in time and effort allocation to restore balance to life. (23)
 12. Increase activities that reinforce a positive self-identity. (24, 25)
 23. Assist the client in identifying areas of life that need modification in order to restore balance in his/her life (e.g., adequate exercise, proper nutrition and sleep, socialization and reaction activities, spiritual development, conjoint activities with partner as well as individual activities and interests, service to others as well as self-indulgence); develop a plan of implementation (or assign “What Needs to be Changed in My Life?” from the *Adult Psychotherapy Homework Planner* by Jongsma).
 24. Assist the client in clarifying his/her identity and meaning in life by listing his/her strengths, positive traits and talents, potential ways to contribute to society, and areas of interest and ability that have not yet been developed (or assign “What’s Good About Me and My Life?” from the *Adult Psychotherapy Homework Planner* by Jongsma).
 25. Develop an action plan with the client to increase activities that give meaning and expand his/her sense of identity at a time of transition in life phases (e.g., single to married, employed to homemaker, childless to parent, employed to retired); monitor implementation; suggest the client read material on transitioning in life (e.g., *Managing*

Transitions: Making the Most of Change or *Transitions: Making Sense of Life's Changes* by Bridges).

13. Increase social contacts to reduce sense of isolation. (26, 27)
14. Share emotional struggles related to current adjustment stress. (28, 29)
26. Explore opportunities for the client to overcome his/her sense of isolation (e.g., joining a community recreational or educational group, becoming active in church or synagogue activities, taking formal education classes, enrolling in an exercise group, joining a hobby support group); encourage implementation of these activities.
27. Use role-playing and modeling to teach the client social skills needed to reach out to build new relationships (e.g., starting conversations, introducing self, asking questions of others about themselves, smiling and being friendly, inviting new acquaintances to his/her home, initiating a social engagement or activity with a new acquaintance).
28. Explore the client's feelings, coping mechanisms, and support system as he/she tries to adjust to the current life stress factors; assess for depth of depression, anxiety, or grief and recommend treatment focused on these problems if warranted (see the Unipolar Depression, Anxiety, and Grief/Loss Unresolved chapters in this *Planner*).
29. Assess the client for suicide potential if feelings of depression, helplessness, and isolation are present; initiate suicide prevention precautions, if necessary (see the Suicidal Ideation chapter in this *Planner*).

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| <p>15. Significant others offer support to reduce the client's stress. (30)</p> | <p>30. Hold family therapy sessions in which significant others are given the opportunity to support the client and offer suggestions for reducing his/her stress; challenge the client to share his/her needs assertively and challenge significant others to take responsibility for support (e.g., partner to increasing parenting involvement, partner to support the client's need for affirmation and stimulation outside the home, family members to take more responsibility for elderly parent's care).</p> |
| <p>16. Read self-help book on the difficult transition life is presenting currently. (31)</p> | <p>31. Suggest reading material to the client on making the transition that is stressful (e.g., new marriage, new parent, becoming full-time homemaker, providing care to an aging parent, retirement, or adjusting to an "empty nest"); consult the Bibliotherapy Appendix for selected titles.</p> |
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	V62.89	Phase of Life Problem
	313.82	Identity Problem
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	309.0	Adjustment Disorder With Depressed Mood

	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
	309.24	Adjustment Disorder With Anxiety
Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
V62.89	Z60.0	Phase of Life Problem
V61.10	Z63.0	Relationship Distress With Spouse or Intimate Partner
V61.20	Z62.820	Parent-Child Relational Problem
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.28	F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
309.24	F43.22	Adjustment Disorder, With Anxiety

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

PHOBIA

BEHAVIORAL DEFINITIONS

1. Describes a persistent and unreasonable fear of a specific object or situation that promotes avoidance behaviors because an encounter with the phobic stimulus provokes an immediate anxiety response.
2. Fears and avoids the phobic stimulus/feared environment or endures it with distress, resulting in interference with normal routines.
3. Acknowledges a persistence of fear despite recognition that the fear is unreasonable.

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LONG-TERM GOALS

1. Reduce fear of the specific phobic object or situation.
2. Reduce avoidance of the specific phobic object or situation, leading to comfort and independence in moving around in a public environment.
3. Eliminate fear of the specific phobic object or situation.
4. Eliminate avoidance of the specific phobic object or situation, leading to comfort and independence in moving around in a public environment.

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SHORT-TERM OBJECTIVES

1. Describe the history and nature of the phobia(s), complete with impact on functioning and attempts to overcome it. (1, 2)
2. Complete psychological tests designed to assess features of the phobia. (3)
3. Participate in a behavioral assessment task. (4)
4. Disclose any history of substance use that may contribute to and complicate the treatment of the phobia. (5)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance; explore and identify the objects or situations that precipitate the client's phobic fear.
2. Assess the client's fear and avoidance, including the focus of the fear, types of avoidance (e.g., distraction, escape, dependence on others), development of the fear, and disability resulting from the fear (consider using *The Anxiety Disorders Interview Schedule-Adult Version*).
3. Administer a client-report measure (e.g., *Measures for Specific Phobia* by Antony; the *Fear Survey Schedule-III*) to further assess the depth and breadth of phobic responses; readminister as needed to assess treatment outcome.
4. Conduct a behavioral assessment task in which the client is asked to approach, under his/her own direction, the feared object or situation while reporting relevant cognitive and emotional experiences; readminister as needed to assess treatment outcome.
5. Arrange for a substance abuse evaluation and refer the client for treatment for if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates

- severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼ 6. Cooperate with an evaluation by a physician for psychotropic medication. (10, 11)
- ▼ 7. Verbalize an accurate understanding of information about phobias and their treatment. (12, 13, 14)
10. Arrange for a medication evaluation to determine the need for a prescription of psychotropic medications if the client requests it or if the client is likely to be noncompliant with gradual exposure. ▼
11. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. ▼
12. Discuss how phobias are a common but irrational expression of our fight or flight response, are not a sign of weakness, but cause unnecessary distress and disability. ▼
13. Discuss how phobic fear is maintained by a “phobic cycle” of unwarranted fear and avoidance that precludes positive, corrective experiences with the feared object or situation, and how treatment breaks the cycle by encouraging exposure to these experiences (see *Mastery of Your Specific Phobia—Therapist Guide* by Craske, Antony, and Barlow; *Specific Phobias* by Bruce and Sanderson). ▼
14. Assign the client to read psychoeducational chapters of books or treatment manuals on specific phobias (e.g., *The Anxiety and Phobia Workbook* by Bourne; *Living with Fear* by Marks; *Mastering Your Fears and Phobia—Workbook* by Antony,

Craske, and Barlow; *Anxiety, Phobias, and Panic: A Step-by-Step Program for Regaining Control of your Life* by Peurifoy; *Face Your Fears: A Proven Plan to Beat Anxiety, Panic, Phobias, and Obsessions* by Tolin). ▾

- ▾ 8. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment. (15, 16)
- ▾ 9. Learn and implement calming skills to reduce and manage anxiety symptoms that may emerge during encounters with phobic objects or situations. (17, 18, 19)
15. Discuss how phobias involve perceiving unrealistic threats, bodily expressions of fear, and avoidance of what is threatening that interact to maintain the problem; discuss how treatment targets change in each domain (see *Mastery of Your Specific Phobia—Therapist Guide* by Craske, Antony, and Barlow; *Specific Phobias* by Bruce and Sanderson). ▾
16. Discuss how exposure serves as an arena to desensitize learned fear, build confidence, and feel safer by building a new history of success experiences (see *Mastery of Your Specific Phobia—Therapist Guide* by Craske, Antony, and Barlow; *Specific Phobias* by Bruce and Sanderson). ▾
17. Teach the client anxiety management skills (e.g., staying focused on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, positive self-talk) to address anxiety symptoms that may emerge during encounters with phobic objects or situations. ▾
18. Assign the client a homework exercise in which he/she practices daily calming skills; review and reinforce success, problem-solve obstacles toward mastery of the skill. ▾

- ▼^{EB} 10. Learn and implement applied muscle tension skills. (20, 21)
- ▼^{EB} 11. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (22, 23, 24)
19. Use biofeedback techniques to facilitate the client's success at learning calming skills.▼^{EB}
20. Teach the client applied tension in which he/she tenses neck and upper torso muscles to curtail blood flow out of the brain to help prevent fainting during encounters with phobic objects or situations involving blood, injection, or injury (consult "Applied Tension" by Öst and Sterner).▼^{EB}
21. Assign the client a homework exercise in which he/she practices daily applied tension skills; review and reinforce success, problem-solve obstacles toward mastery of the skill.▼^{EB}
22. Explore the client's self-talk and schema that mediate his/her fear response; assist in identify biases, generate alternatives that correct for the biases; and replacing distorted messages with reality-based alternatives.▼^{EB}
23. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, problem-solve obstacles toward mastery of the skill.▼^{EB}
24. Use behavioral techniques (e.g., modeling, corrective feedback, imaginal rehearsal, social reinforcement) to train the client in positive self-talk that prepares him/her to endure anxiety symptoms without serious consequences.▼^{EB}

- ▽^{EB} 12. Participate in repeated exposure to feared or avoided phobic objects or situations. (25, 26, 27, 28)
25. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response; include imaginal situations if needed to accommodate excessive fear. ▽^{EB}
26. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms and rehearse the plan. ▽^{EB}
27. Assign the client a homework exercise in which he/she does imaginal and/or situational exposures and records responses (see “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma; *Mastering Your Fears and Phobia—Workbook* by Antony, Craske, and Barlow; *Living with Fear* by Marks); review and reinforce success, problem-solve obstacles toward the extinction of fear and elimination of phobic avoidance. ▽^{EB}
28. Assign the client behavioral experiments in which biased, fear-based predictions are tested against alternatives that correct for the biases during exposure exercises; review and reinforce success, problem-solve obstacles toward belief in the alternatives and the elimination of phobic avoidance. ▽^{EB}
- ▽^{EB} 13. Implement relapse prevention strategies for preventing and/or managing possible future anxiety symptoms. (29, 30, 31, 32, 33)
29. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary and reversible return of symptoms, fear, or urges to avoid

and relapse with the decision to return to fearful and avoidant patterns. ^{EB}▼

30. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. ^{EB}▼
31. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into his/her life as much as possible. ^{EB}▼
32. Develop a “coping card” or other recording on which coping strategies and other therapeutic important information that the client found useful (e.g., coping strategies, cognitive messages) are made available for the client’s later use. ^{EB}▼
33. Schedule a “booster session” for the client 1 to 3 months after therapy ends to reinforce gains and problem-solve any obstacles to progress. ^{EB}▼
14. Learn to accept anxious thinking and tolerate, rather than avoid, unpleasant emotions while accomplishing meaningful goals. (34, 35, 36)
34. Use an Acceptance and Commitment Therapy approach including mindfulness strategies to help the client decrease experiential avoidance, disconnect thoughts from actions, accept one’s experience rather than change or control symptoms, and behave according to his/her broader life values; assist the client in clarifying his/her values and goals and commit to behaving accordingly (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).
35. Recommend that the client read self-help books consistent with the ACT approach to help supplement

therapy and foster better understanding of it (e.g., see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert); process material read.

- 15. Verbalize the costs and benefits of remaining fearful and avoidant. (37)
- 16. Verbalize the separate realities of the irrationally feared object or situation and the emotionally painful experience from the past that has been evoked by the phobic stimulus. (38, 39, 40)
- 36. Support the client in following through with his/her commitments toward having a meaningful and fulfilling work, family, and social life.
- 37. Probe for the presence of secondary gain that reinforces the client's phobic actions through escape or avoidance mechanisms; address gain directly if evident; encourage and support change.
- 38. Clarify and differentiate between the client's current irrational fear and past emotional pain.
- 39. Encourage the client's sharing of feelings associated with past traumas through active listening, positive regard, and questioning.
- 40. Work through past pain with the client toward insight into its relationship with the present fear.

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DIAGNOSTIC SUGGESTIONS


Using DSM-IV/ICD-9-CM:

Axis I:	300.29	Specific Phobia
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.29	F40.xxx	Specific Phobia

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

POSTTRAUMATIC STRESS DISORDER (PTSD)

BEHAVIORAL DEFINITIONS

1. Has been exposed to a traumatic event involving actual or perceived threat of death or serious injury.
2. Reports response of intense fear, helplessness, or horror to the traumatic event.
3. Experiences disturbing and persistent thoughts, images, and/or perceptions of the traumatic event.
4. Experiences frequent nightmares.
5. Describes a reliving of the event, particularly through dissociative flashbacks.
6. Displays significant psychological and/or physiological distress resulting from internal and external clues that are reminiscent of the traumatic event.
7. Intentionally avoids thoughts, feelings, or discussions related to the traumatic event.
8. Intentionally avoids activities, places, people, or objects (e.g., up-armored vehicles) that evoke memories of the event.
9. Displays a significant decline in interest and engagement in activities.
10. Experiences disturbances in sleep.
11. Reports difficulty concentrating as well as feelings of guilt.
12. Reports hypervigilance
13. Demonstrates an exaggerated startle response.
14. Symptoms present more than one month.
15. Impairment in social, occupational, or other areas of functioning.

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LONG-TERM GOALS

1. Eliminate or reduce the negative impact trauma related symptoms have on social, occupational, and family functioning.
2. Returns to the level of psychological functioning prior to exposure to the traumatic event.
3. No longer experiences intrusive event recollections, avoidance of event reminders, intense arousal, or disinterest in activities or relationships.
4. Thinks about or openly discusses the traumatic event with others without experiencing psychological or physiological distress.
5. No longer avoids persons, places, activities, and objects that are reminiscent of the traumatic event.

SHORT-TERM OBJECTIVES

1. Describe in as much detail as comfort allows the nature and history of the PTSD symptoms. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Gently and sensitively explore the client’s recollection of the facts of the traumatic incident and his/her cognitive and emotional reactions at the time; assess frequency, intensity, duration, and history of the client’s PTSD symptoms and their impact on functioning (see “How the Trauma Affects Me” in the *Adult Psychotherapy*)

Homework Planner by Jongsma); supplement with semi-structured assessment instrument if desired (see *The Anxiety Disorders Interview Schedule—Adult Version*).

2. Cooperate with psychological testing. (3)
3. Acknowledge any substance use. (4, 5)
4. Verbalize any symptoms of depression, including any suicidal thoughts. (6)
5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)
3. Administer or refer the client for administration of psychological testing or objective measures of the PTSD symptoms and/or other comorbidity (e.g., *Minnesota Multiphasic Personality Inventory–2*; *Impact of Events Scale-Revised*; *PTSD Symptom Scale*; *Posttraumatic Stress Diagnostic Scale*); discuss results with the client; readminister as indicated to assess treatment progress).
4. Assess the client for the presence and degree of substance abuse or dependence.
5. Refer the client for a more comprehensive substance use evaluation and treatment.
6. Assess the client's depth of depression and suicide potential and treat appropriately, taking the necessary safety precautions as indicated (see the Suicidal Ideation chapter in this *Planner*).
7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to

address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 9. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 10. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 11. Assess the client’s need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate. ▾
- ▾ 6. Cooperate with a psychiatric evaluation to assess for the need for psychotropic medication. (11, 12)

- ▽ 7. Verbalize an accurate understanding of PTSD and how it develops. (13)
- ▽ 8. Verbalize an understanding of the treatment rationale for PTSD. (14, 15)
- ▽ 9. Learn and implement calming skills. (16)
- ▽ 10. Participate in Cognitive Processing Therapy to process the trauma and reduce its impact. (17, 18, 19, 20)
- 12. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning. ▽
- 13. Discuss how PTSD results from exposure to trauma; results in intrusive recollection, unwarranted fears, anxiety, and a vulnerability to other negative emotions such as shame, anger, and guilt; and results in avoidance of thoughts, feelings, and activities associated with the trauma. ▽
- 14. Educate the client about how effective treatments for PTSD help address the cognitive, emotional, and behavioral consequences of PTSD using cognitive and behavioral therapy approaches. ▽
- 15. Assign the client to read psychoeducational chapters of books or treatment manuals on PTSD that explain its features and development (e.g., *Overcoming Posttraumatic Stress Disorder* by Smyth; *Reclaiming Your Life from a Traumatic Experience* by Rothbaum, Foa, and Hembree). ▽
- 16. Teach the client calming skills (e.g., breathing retraining, relaxation, calming self-talk) to use in and between sessions when feeling overly distressed. ▽
- 17. Use a Cognitive Processing Therapy approach beginning with assigning the client to write a description of the meaning of the traumatic event (i.e., the impact

statement); ask the client to read and discuss the impact statement (see *Posttraumatic Stress Disorder* by Resick, Monson, and Rizvi; *Cognitive Processing Therapy for Rape Victims* by Resick and Schnicke). ▽

18. Teach the client the relationship between thoughts, behaviors, and emotions associated with the trauma. ▽
19. Ask the client to write a detailed description of the traumatic event and read the statement in session (or assign “Share the Painful Memory” in the *Adult Psychotherapy Homework Planner* by Jongsma); use cognitive therapy techniques to question biased thoughts and beliefs and explore unbiased alternatives; repeat this process until a shift from biased to unbiased thinking is evident. ▽
20. Ask the client to rewrite a description of the event, but now reflecting new thoughts and beliefs; discuss this restructured version of the event reinforcing the new beliefs; assess and address themes common to PTSD (e.g., safety, trust, power, control, esteem, and intimacy). ▽
- ▽ 11. Participate in Cognitive Therapy to help identify, challenge, and replace biased, negative, and self-defeating thoughts resulting from the trauma. (21, 22, 23)
21. Using Cognitive Therapy techniques, explore the client’s self-talk and beliefs about self, others, and the future that are a consequence of the trauma (e.g., themes of safety, trust, power, control, esteem, and intimacy); identify and challenge biases; assist him/her in generating appraisals that correct for the

- biases; test biased and alternatives predictions through behavioral experiments. ▾
22. Assign the client to keep a daily log of automatic thoughts (e.g., “Negative Thoughts Trigger Negative Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to challenge distorted thinking patterns with reality-based thoughts and to generate predictions for behavioral experiments. ▾
 23. Assign the client a homework exercise in which he/she identifies fearful self-talk; tests, through behavioral experiments, the predictions from these dysfunctional thoughts; and creates reality-based alternatives. Review and reinforce success while problem-solving obstacles toward sustaining positive change (see *Overcoming Posttraumatic Stress Disorder* by Smyth). ▾
 24. Direct and assist the client in constructing a fear and avoidance hierarchy of trauma-related stimuli. ▾
 25. Utilize in vivo exposure in which the client gradually exposes himself/herself to objects, situations, places negatively associated with the trauma. ▾
 26. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (see “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma
- ▾ 12. Participate in Prolonged Exposure Therapy to reduce fear and avoidance associated with the trauma. (24, 25, 26, 27, 28)

or *Overcoming Posttraumatic Stress Disorder* by Smyth); review and reinforce progress, problem-solve obstacles. ▽

27. Utilize imaginal exposure to process memories of the trauma, at a client-chosen level of detail, for an extended period of time (e.g., 90 minutes); repeat in future sessions until distress reduces and stabilizes (see *Prolonged Exposure Therapy for PTSD* by Foa, Hembree, and Rothbaum; or *Posttraumatic Stress Disorder* by Resick, Monson, and Rizvi). ▽
 28. Assign the client a homework exercise in which he or she does self-directed exposure to the memory of the trauma. ▽
 29. Use techniques from Stress Inoculation Training (e.g., covert modeling [i.e., imagining the successful use of the strategies], role-play, practice, and generalization training) to teach the client tailored skills (e.g., calming and coping skills) for managing fears, overcoming avoidance, and increasing present-day adaptation (see *Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Posttraumatic Stress Disorder (PTSD)* by Meichenbaum). ▽
 30. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenges its biases, copes with engendered feelings, overcomes avoidance, and reinforces his/her accomplishments; review and
- ▽ 13. Learn and implement personal skills to manage challenging situations related to trauma. (29)
 - ▽ 14. Learn and implement guided self-dialogue to manage thoughts, feelings, and urges brought on by encounters with trauma-related situations. (30)

- reinforce progress, problem-solve obstacles. ▽
- ▽ 15. Participate in Eye Movement Desensitization and Reprocessing (EMDR) to reduce emotional distress related to traumatic thoughts, feelings, and images. (31)
16. Participate in Acceptance and Commitment Therapy (ACT) to reduce the impact of the traumatic event. (32, 33, 34, 35)
31. Utilize Eye Movement Desensitization and Reprocessing (EMDR) to reduce the client's emotional reactivity to the traumatic event and reduce PTSD symptoms. ▽
32. Use an ACT approach to PTSD to help the client experience and accept the presence of troubling thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).
33. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
34. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.
35. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Finding Life Beyond*

Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems by Follette and Pistorello).

17. Acknowledge the need to implement anger control techniques; learn and implement anger management techniques. (36, 37)
18. Learn and implement approaches for addressing shame and self-disparagement. (38)
19. Implement a regular exercise regimen as a stress release technique. (39, 40)
20. Sleep without being disturbed by dreams of the trauma. (41)
36. Assess the client for instances of poor anger management that have led to threats or actual violence that caused damage to property and/or injury to people (or assign “Anger Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma).
37. Teach the client anger management techniques (see the Anger Control Problems chapter in this *Planner*).
38. Use a Compassionate Mind Training to help the client identify and change self-attacking and personal shaming resulting from the trauma (see *Focused Therapies and Compassionate Mind Training for Shame and Self-Attacking* by Gilbert and Irons).
39. Develop and encourage a routine of physical exercise for the client.
40. Recommend that the client read and implement programs from *Exercising Your Way to Better Mental Health* by Leith.
41. Monitor the client’s sleep pattern (or assign “Sleep Pattern Record” in the *Adult Psychotherapy Homework Planner* by Jongsma) and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep (see the Sleep Disturbance chapter in this *Planner*).

21. Participate in conjoint and/or family therapy sessions. (42)
22. Participate in group therapy sessions focused on PTSD. (43)
23. Verbalize an understanding of relapse prevention. (44, 45, 46)
24. Learn and implement strategies to prevent relapse of PTSD. (47, 48, 49)
42. Conduct family and conjoint sessions to facilitate healing of hurt caused by the client's symptoms of PTSD.
43. Refer the client to or conduct group therapy sessions emphasizing the sharing of traumatic events and their effects with other PTSD survivors.
44. Provide the client with a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.
45. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of thinking, feeling, and behaving that is characteristic of PTSD.
46. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.
47. Instruct the client to routinely use strategies learned in therapy (e.g., continued everyday exposure, cognitive restructuring, problem-solving), building them into his/her life as much as possible.
48. Develop a "coping card" or other reminder on which coping strategies and other important information can be recorded (e.g., steps in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

- 49. Schedule periodic maintenance or “booster” sessions to help the client maintain therapeutic gains and problem-solve challenges.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	309.81 300.14 300.6 300.15 995.54 995.81 995.53 995.83 308.3 304.80 305.00 303.90 304.30 304.20 304.00 296.xx _____ _____	Posttraumatic Stress Disorder Dissociative Identity Disorder Depersonalization Disorder Dissociative Disorder NOS Physical Abuse of Child, Victim Physical Abuse of Adult, Victim Sexual Abuse of Child, Victim Sexual Abuse of Adult, Victim Acute Stress Disorder Polysubstance Dependence Alcohol Abuse Alcohol Dependence Cannabis Dependence Cocaine Dependence Opioid Dependence Major Depressive Disorder _____ _____
Axis II:	301.83 301.9 _____ _____	Borderline Personality Disorder Personality Disorder NOS _____ _____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.81	F43.10	Posttraumatic Stress Disorder
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.89	Other Specified Dissociative Disorder
300.15	F44.9	Unspecified Dissociative Disorder
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
995.81	T74.11XA	Spouse or Partner Violence, Physical, Confirmed, Initial Encounter
995.81	T74.11XD	Spouse or Partner Violence, Physical, Confirmed, Subsequent Encounter
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter
308.3	F43.0	Acute Stress Disorder
305.00	F10.10	Alcohol Use Disorder, Mild
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

PSYCHOTICISM

BEHAVIORAL DEFINITIONS

1. Verbalizes bizarre content of thought (delusions of grandeur, persecution, reference, influence, control, somatic sensations, or infidelity).
2. Demonstrates abnormal speech patterns including tangential replies, incoherence, perseveration, and moving quickly from subject to subject.
3. Describes perceptual disturbance or hallucinations (auditory, visual, tactile, or olfactory).
4. Exhibits disorganized behavior, such as confusion, severe lack of goal direction, impulsiveness, or repetitive behaviors.
5. Expresses paranoid thoughts and exhibits paranoid reactions, including extreme distrust, fear, and apprehension.
6. Exhibits psychomotor abnormalities such as a marked decrease in reactivity to environment; catatonic patterns such as stupor, rigidity, excitement, posturing, or negativism as well as unusual mannerisms or grimacing.
7. Displays extreme agitation, including a high degree of irritability, anger, unpredictability, or impulsive physical acting out.
8. Exhibits bizarre dress or grooming.
9. Demonstrates disturbed affect (blunted, none, flattened, or inappropriate).
10. Demonstrates relationship withdrawal (withdrawal from involvement with the external world and preoccupation with egocentric ideas and fantasies, feelings of alienation).

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LONG-TERM GOALS

1. Control or eliminate active psychotic symptoms so that functioning is positive and medication is taken consistently.
2. Eliminate acute, reactive, psychotic symptoms and return to normal functioning.
3. Increase goal-directed behaviors.
4. Focus thoughts on reality.
5. Normalize speech patterns, which can be evidenced by coherent statements, attentions to social cues, and remaining on task.
6. Interact with others without defensiveness or anger.
7. Achieve and maintain an active, personally effective recovery approach.

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SHORT-TERM OBJECTIVES

1. Provide the history and the current status of psychotic symptoms. (1, 2)

2. Participate in psychological testing that will help increase understanding of the condition. (3)

THERAPEUTIC INTERVENTIONS

1. Demonstrate acceptance to the client through a calm, nurturing manner, good eye contact, and active listening; approach an acutely psychotic client in a calm, confident, open, direct, yet soothing manner (e.g., approach slowly, face toward the client with open body language, speak slowly and clearly).
2. Assess the client’s history of psychotic symptoms including current symptoms and the impact they have had on functioning.
3. Coordinate psychological and/or neuropsychological testing to assess the extent and the severity of the client’s psychotic symptoms.

3. Allow family members to participate in the assessment of the condition. (4)
4. Cooperate with a physician's evaluation of medical health. (5)
5. Disclose substance abuse as a precipitating trigger for psychotic symptoms. (6, 7)
6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)
4. Request that a family member provide information about the client's history of psychotic behaviors.
5. Refer the client for a complete medical evaluation to rule out possible general medical and substance-related etiologies.
6. Use a Motivational Interviewing approach toward engaging the client in the process of discontinuing substance use, including drugs, alcohol, nicotine, and caffeine (see the Substance Use chapter in this *Planner*).
7. Refer the client to a substance abuse treatment program.
8. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if

appropriate (e.g., increased suicide risk when comorbid depression is evident).

10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 12. Refer the client for an immediate evaluation by a psychiatrist regarding his/her psychotic symptoms and a possible prescription for antipsychotic medication. ^{EB}▽
 13. Coordinate voluntary or involuntary psychiatric hospitalization if the client is a threat to himself/herself or others and/or is unable to provide for his/her own basic needs. ^{EB}▽
 14. Arrange for the client to remain in a stable, supervised situation (e.g., adult foster care [AFC] placement or a friend's/family member's home). ^{EB}▽
- ^{EB}▽ 7. Cooperate with services focused on stabilizing the current acute psychotic episode. (12, 13, 14, 15)

8. Decrease the risk of suicide. (16, 17)
9. Obtain immediate, temporary support or supervision from friends, peers, or family members. (18, 19)
- ▽ 10. Report a decrease in psychotic symptoms through the consistent use of psychotropic medications. (20, 21)
- ▽ 11. Participate with family and/or significant others in a therapy designed to improve quality of
15. Coordinate mobile crisis response services (e.g., physical exam, psychiatric evaluation, medication access, triage to inpatient care, etc.) in the client's home environment (including jail, personal residence, homeless shelter, or street setting). ▽
16. Perform a suicide assessment and take all necessary precautionary steps (see the Suicidal Ideation chapter in this *Planner*).
17. Remove potentially hazardous materials, such as firearms or excess medication, if indicated.
18. Develop a crisis plan to provide supervision and support to the client on an intensive basis.
19. Coordinate access to round-the-clock, professional consultation (e.g., a 24-hour professionally staffed crisis line) to caregivers and the client.
20. Educate the client about the use and expected benefits of psychotropic medications; encourage consistent taking of prescribed medications (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
21. Monitor the client's medication compliance, effectiveness, and side-effect risk (e.g., tardive dyskinesia, muscle rigidity, dystonia, metabolic effects such as weight gain). ▽
22. Conduct a family-based intervention beginning with psychoeducation emphasizing

life for all members and facilitate personal recovery. (22)

the biological nature of psychosis, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, early episode intervention, and social support (see *Family Care of Schizophrenia* by Falloon, Boyd, and McGill).^{EB}

^{EB} 12. Learn and implement effective communication skills with family and/or significant others. (23, 24)

23. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and the risk for the client's relapse; emphasize the positive role of social support.^{EB}

24. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills (e.g., offering positive feedback; active listening; making positive requests of others for behavior change; and giving constructive feedback in an honest and respectful manner).^{EB}

^{EB} 13. Implement problem-solving skills with family and/or significant others to address problems that arise. (25, 26)

25. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.^{EB}

26. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills (i.e., defining the problem constructively and specifically;

- brainstorming solution options; evaluating the pros and cons of the options; choosing an option and implementing a plan; evaluating the results; and adjusting the plan).[▽]
- ▽ 14. Complete exercises between sessions to practice newly learned personal and interpersonal skills. (27)
- ▽ 15. Develop and participate in a family relapse prevention and management plan in the event that psychotic symptoms return. (28)
- ▽ 16. Participate in a psychoeducational program with other families. (29)
- ▽ 17. Identify internal and environmental triggers of psychotic symptoms. (30)
27. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills; process results in session toward effective use; problem-solve obstacles; (assign “Plan Before Acting” or “Problem-Solving: An Alternative to Impulsive Action” in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session.[▽]
28. Help the client and family draw up a “relapse drill” detailing roles and responsibilities (e.g., who will call a meeting of the family to problem-solve potential relapse; who will call the client’s physician, schedule a serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan.[▽]
29. Refer the family to a multigroup family psychoeducational program (see *Multifamily Groups in the Treatment of Severe Psychiatric Disorders* by McFarland).[▽]
30. Help the client identify specific behaviors, situations, thoughts, and feelings associated with symptom exacerbations.[▽]

- ▼^{EB} 18. Identify current reactions to symptoms and their impact on self and others. (31, 32)
- ▼^{EB} 19. Learn and implement skills that increase personal effectiveness and resistance to subsequent psychotic episodes. (33, 34, 35)
31. Help the client identify his/her emotional and behavioral reactions as well as other consequences of psychotic symptoms toward the goal of increasing his/her understanding of these reactions and how they impact functioning adaptively or maladaptively (e.g., withdrawal leading to isolation and loneliness; paranoid accusations leading to negative reactions of others that falsely support the delusion). ▼^{EB}
32. Assess adaptive and maladaptive strategies that the client is using to cope with psychotic symptoms; reinforce adaptive strategies. ▼^{EB}
33. Tailor cognitive behavioral strategies so the client can restructure psychotic cognition, learn effective personal and interpersonal skills, and develop coping and compensation strategies for managing psychotic symptoms (see *Treating Complex Cases: The Cognitive Behavioural Therapy Approach* by TARRIER, WELLS, and HADDOCK). ▼^{EB}
34. Desensitize the client's fear of his/her hallucinations by allowing or encouraging him/her to talk about them, their frequency, their intensity, and their meaning (or assign "What Do You Hear and See?" in the *Adult Psychotherapy Homework Planner* by JONGSMA); provide a reality alternative view of the world. ▼^{EB}
35. Use education, modeling, role-play, reinforcement, and other

cognitive-behavioral strategies to teach the client coping and compensation strategies for managing psychotic symptoms (e.g., calming techniques; attention switching and narrowing; realistic self-talk; realistic attribution of the source of the symptom; and increased adaptive personal and social activity).^{EB}

- ▼^{EB} 20. Identify and change self-talk and beliefs that interfere with recovery. (36, 37)
- ▼^{EB} 21. Verbalize an understanding of the need to learn new and improved social skills. (38)
- ▼^{EB} 22. Participate in individual or group therapy focused on improving social effectiveness. (39)
- ▼^{EB} 36. Use Cognitive Therapy techniques to explore biased self-talk and beliefs that contribute to delusional thinking; assist the client in identifying and challenging the biases, generating alternative appraisals that correct biases, building confidence, and improving adaptation.^{EB}
- ▼^{EB} 37. Assign the client homework exercises in which he/she identifies biased self-talk, creates reality-based alternatives, and tests them in his/her experience; review and reinforce success, providing corrective feedback toward facilitating sustained, positive change (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}
- ▼^{EB} 38. Provide a rationale for social skills training that communicates the benefits of improved social interactions and decreased negative social actions.^{EB}
- ▼^{EB} 39. Provide or refer the client to individual or group social skills training that employs cognitive-behavioral strategies (e.g., education, modeling, role-play,

- practice, reinforcement, and generalization) to teach the client relevant social skills (e.g., conversation, assertiveness, conflict resolution) to improve his/her ability to attain and maintain social relationships (or assign “Restoring Socialization Comfort” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
- ▽^{EB} 23. Read about social skills training in books or manuals recommended by the therapist. (40)
- ▽^{EB} 24. Practice and strengthen skills learned in therapy. (41)
- ▽^{EB} 25. Participate in a therapy to practice mental tasks and learn strategies to improve mental, emotional, and social functioning. (42)
40. Use prescribed reading assignments from books or treatment manuals consistent with therapeutic skill being taught to facilitate the client’s acquisition of it (e.g., *Your Perfect Right* by Alberti and Emmons for assertiveness skills; *Con conversationally Speaking* by Garner for conversational skills).^{EB}▽
41. Prescribe in- and between-session exercises that allow the client to practice new skills, reality test and challenge his/her maladaptive beliefs, and consolidate a new approach to adaptive functioning and symptom management; review; reinforce positive change; problem-solve obstacles toward consolidating the client’s skills.^{EB}▽
42. Provide or refer the client to a Cognitive Remediation/ Neurocognitive Therapy program that uses repeated practice of cognitive tasks and/or strategy training to restore cognitive function and/or teach compensatory strategies for cognitive impairments and improve cognitive, emotional, and social functioning (see *Cognitive Remediation Therapy*

for Schizophrenia by Wykes and Reeder).^{EE} ▽

- ▽ 26. Participate in a training program to build job skills. (43)
- 27. Verbalize the acceptance of mental illness and willingness to engage in recovery, decreasing feelings of stigmatization. (44)
- 28. Attend a support group for others with severe mental illness. (45)
- 43. Refer the client to a Supported Employment program to build occupational skills and improve overall functioning and quality of life.^{EE} ▽
- 44. Encourage the client to express his/her feelings related to acceptance of the mental illness and engagement in recovery; reinforce thoughts and actions that strengthen the client's engagement in the recovery process.
- 45. Refer the client to a support group for individuals with a mental illness with the goal of helping consolidate their new approach to recovery and gain social support for it.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:


Axis I:	297.1	Delusional Disorder
	298.8	Brief Psychotic Disorder
	295.xx	Schizophrenia
	295.30	Schizophrenia, Paranoid Type
	295.70	Schizoaffective Disorder
	295.40	Schizophreniform Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder

296.xx	Major Depressive Disorder
310.1	Personality Change Due to Axis III Disorder

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
297.1	F22	Delusional Disorder
298.8	F23	Brief Psychotic Disorder
295.30	F20.9	Schizophrenia
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
295.40	F20.40	Schizophreniform Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
310.1	F07.0	Personality Change Due to Another Medical Condition
298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

SEXUAL ABUSE VICTIM

BEHAVIORAL DEFINITIONS

1. Vague memories of inappropriate childhood sexual contact that can be corroborated by significant others.
2. Self-report of being sexually abused with clear, detailed memories.
3. Inability to recall years of childhood.
4. Extreme difficulty becoming intimate with others.
5. Inability to enjoy sexual contact with a desired partner.
6. Unexplainable feelings of anger, rage, or fear when coming into contact with a close family relative.
7. Pervasive pattern of promiscuity or the sexualization of relationships.

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LONG-TERM GOALS

1. Resolve the issue of being sexually abused with an increased capacity for intimacy in relationships.
2. Begin the healing process from sexual abuse with resultant enjoyment of appropriate sexual contact.
3. Work successfully through the issues related to being sexually abused with consequent understanding and control of feelings.
4. Recognize and accept the sexual abuse without inappropriate sexualization of relationships.
5. Establish whether sexual abuse occurred.

6. Begin the process of moving away from being a victim of sexual abuse and toward becoming a survivor of sexual abuse.

SHORT-TERM OBJECTIVES

1. Tell the story of the nature, frequency, and duration of the abuse. (1, 2, 3)

2. Disclose any emotional problems resulting from the sexual abuse. (4)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Gently explore the client’s sexual abuse experience without pressing early for unnecessary details.
3. Ask the client to draw a diagram of the house in which he/she was raised, complete with where everyone slept.
4. Assess the client for psychological problems secondary to the sexual abuse; if the client’s experiences with sexual abuse are currently manifesting as a clinical syndrome (e.g., PTSD, depression), conduct or refer to an evidence-based intervention for the disorder (see, for example, PTSD or Unipolar Depression chapters in this *Planner*).

3. Disclose any history of substance use that may contribute to and complicate the treatment of sexual abuse. (5)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the

- client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Identify a support system of key individuals who will be encouraging and helpful in aiding the process of resolving the issue. (10, 11)
 6. Verbalize an increased knowledge of sexual abuse and its effects. (12, 13)
 7. Identify and express the feelings connected to the abuse. (14, 15)
 10. Help the client identify those individuals who would be compassionate and encourage him/her to enlist their support.
 11. Encourage the client to attend a support group for survivors of sexual abuse.
 12. Assign the client to read material on sexual abuse (e.g., *The Courage to Heal* by Bass and Davis; *Betrayal of Innocence* by Forward and Buck; *Outgrowing the Pain* by Gil; *Reclaiming Your Life After Rape: Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder—Client Workbook* by Rothbaum and Foa); process key concepts.
 13. Assign and process a written exercise from *Healing the Trauma of Abuse: A Women's Workbook* by Copeland and Harris.
 14. Explore, encourage, and support the client in verbally expressing and clarifying feelings associated with the abuse.
 15. Encourage the client to be open in talking of the abuse without

- shame or embarrassment as if he/she was responsible for the abuse.
8. Decrease the secrecy in the family by informing key nonabusive members regarding the abuse. (16, 17, 18)
 9. Describe how a sex abuse experience is part of a family pattern of broken boundaries. (19)
 10. Verbalize the ways the sexual abuse has had an impact on life. (20, 21)
 11. Clarify memories of the abuse. (22, 23)
 16. Guide the client in an empty chair conversation exercise with a key figure connected to the abuse (e.g., perpetrator, sibling, parent) telling them of the sexual abuse and its effects.
 17. Hold a conjoint session where the client tells his/her spouse of the abuse.
 18. Facilitate a family session with the client, assisting and supporting him/her in revealing the abuse to parent(s).
 19. Develop with the client a genogram and assist in illuminating key family patterns of broken boundaries related to sex and intimacy through physical contact or verbal suggestiveness.
 20. Ask the client to make a list of the ways sexual abuse has impacted his/her life; process the list content.
 21. Develop with the client a symptom line connected to the abuse.
 22. Refer or conduct hypnosis with the client to further uncover or clarify the nature and extent of the abuse.
 23. Facilitate the client's recall of the details of the abuse by asking him/her to keep a journal and talk and think about the incidents (or assign "Picturing the Place of the Abuse" or "Describe the Trauma" in the *Adult Psychotherapy Homework*

- Planner* by Jongsma). Caution him/her against embellishment based on book, video, or drama material, and be very careful not to lead the client into only confirming therapist-held suspicions.
12. Decrease statements of shame, being responsible for the abuse, or being a victim, while increasing statements that reflect personal empowerment. (24, 25, 26, 27)
 13. Identify the positive benefits for self of being able to forgive all those involved with the abuse. (28, 29, 30)
 24. Assign the client to read material on overcoming shame (e.g., *Healing the Shame That Binds You* by Bradshaw; *Facing Shame* by Fossum and Mason); process key concepts.
 25. Encourage, support, and assist the client in identifying, expressing, and processing any feelings of guilt related to feelings of physical pleasure, emotional fulfillment, or responsibility connected with the events.
 26. Confront and process with the client any statements that reflect taking responsibility for the abuse or indicating he/she is a victim; assist the client in feeling empowered by working through the issues and letting go of the abuse.
 27. Assign the client to complete a cost-benefit exercise (see *Ten Days to Self-Esteem!* by Burns), or a similar exercise, on being a victim versus a survivor or on holding on versus forgiving; process completed exercises.
 28. Read and process the story from *Stories for the Third Ear* by Wallas entitled “The Seedling” (a story for a client who has been abused as a child).
 29. Assist the client in removing any barriers that prevent him/her

- from being able to identify the benefits of forgiving those responsible for the abuse.
14. Express feelings to and about the perpetrator, including the impact the abuse has had both at the time of occurrence and currently. (31, 32, 33)
 15. Increase level of forgiveness of self, perpetrator, and others connected with the abuse. (34)
 16. Increase level of trust of others as shown by more socialization and greater intimacy tolerance. (35, 36)
 30. Recommend that the client read *Forgive and Forget* by Smedes; process the content of the book after the reading is completed.
 31. Assign the client to write an angry letter to the perpetrator of the sexual abuse; process the letter within the session.
 32. Prepare the client for a face-to-face meeting with the perpetrator of the abuse by processing the feelings that arise around the event and role-playing the meeting.
 33. Hold a conjoint session where the client confronts the perpetrator of the abuse; afterward, process his/her feelings and thoughts related to the experience.
 34. Assign the client to write a forgiveness letter and/or complete a forgiveness exercise (or assign “A Blaming Letter and a Forgiving Letter to Perpetrator” in the *Adult Psychotherapy Homework Planner* by Jongsma); process each with therapist.
 35. Teach the client the share-check method of building trust in relationships (i.e., share only a little of self and then check to be sure that the shared data is treated respectfully, kindly, and confidentially; as proof of trustworthiness is verified, share more freely).

- 17. Report increased ability to accept and initiate appropriate physical contact with others. (37, 38)

- 18. Verbally identify self as a survivor of sexual abuse. (39, 40)

- 36. Use role-playing and modeling to teach the client how to establish reasonable personal boundaries that are neither too porous nor too restrictive.
- 37. Encourage the client to give and receive appropriate touches; help him/her define what is appropriate.
- 38. Ask the client to practice one or two times a week initiating appropriate touching or a touching activity (i.e., giving a back rub to spouse, receiving a professional massage, hugging a friend, etc.).
- 39. Reinforce with the client the benefits of seeing himself/herself as a survivor rather than the victim and work to remove any barriers that remain in the way of him/her doing so (or assign “Changing from Victim to Survivor” in the *Adult Psychotherapy Homework Planner* by Jongsma).
- 40. Give positive verbal reinforcement when the client identifies himself/herself as a survivor.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	304.80	Polysubstance Dependence
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.02	Generalized Anxiety Disorder
	300.14	Dissociative Identity Disorder
	300.15	Dissociative Disorder NOS
	995.53	Sexual Abuse of Child, Victim
	995.83	Sexual Abuse of Adult, Victim
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Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.02	F41.1	Generalized Anxiety Disorder
300.14	F44.81	Dissociative Identity Disorder
300.15	F44.89	Other Specified Dissociative Disorder
300.15	F44.9	Unspecified Dissociative Disorder
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter

301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

SEXUAL IDENTITY CONFUSION*

BEHAVIORAL DEFINITIONS

1. Uncertainty about basic sexual orientation.
2. Difficulty in enjoying sexual activities with opposite sex partner because of low arousal.
3. Sexual fantasies and desires about same-sex partners, which causes distress.
4. Sexual activity with person of same sex that has caused confusion, guilt, and anxiety.
5. Depressed mood, diminished interest in activities.
6. Marital conflicts caused by uncertainty about sexual orientation.
7. Feelings of guilt, shame, and/or worthlessness.
8. Concealing sexual identity from significant others (e.g., friends, family, spouse).

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LONG-TERM GOALS

1. Identify sexual identity and engage in a wide range of relationships that are supportive of that identity.

* Most of the content of this chapter (with only slight revisions) originates from J. M. Evosevich and M. Avriette, *The Gay and Lesbian Psychotherapy Treatment Planner* (Hoboken, NJ: Wiley, 2000). Copyright © 2000 by J. M. Evosevich and M. Avriette. Reprinted with permission.

2. Reduce overall frequency and intensity of the anxiety associated with sexual identity so that daily functioning is not impaired.
3. Disclose sexual orientation to significant others.
4. Return to previous level of emotional, psychological, and social functioning.
5. Eliminate all feelings of depression (e.g., depressed mood, guilt, worthlessness).

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

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| <ol style="list-style-type: none"> 1. Describe fear, anxiety, and distress about confusion over sexual identity. (1) 2. Disclose any history of substance use that may contribute to and complicate the treatment of sexual identity confusion. (2) 3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a <i>DSM</i> diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6) | <ol style="list-style-type: none"> 1. Actively build trust with the client and encourage his/her expression of fear, anxiety, and distress over sexual identity confusion. 2. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this <i>Planner</i>). 3. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; |
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or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 7. Assess the client’s current sexual functioning by asking him/her about previous sexual history, fantasies, and thoughts.
4. Identify sexual experiences that have been a source of excitement, satisfaction, and emotional gratification.
(7, 8, 9, 10)

5. Verbalize an understanding of how cultural, racial, and/or ethnic identity factors contribute to confusion about sexual identity. (11)
6. Write a “future” biography detailing life as a heterosexual and as a homosexual to assist in identifying primary orientation. (12)
7. Verbalize an understanding of the range of sexual identities possible. (13, 14)
8. Assist the client in identifying sexual experiences that have been a source of excitement, satisfaction, and emotional gratification.
9. To assist the client in increasing his/her awareness of sexual attractions and conflicts, assign him/her to write a journal describing sexual thoughts, fantasies, and conflicts that occur throughout the week (or assign “Journal of Sexual Thoughts, Fantasies, Conflicts” from the *Adult Psychotherapy Homework Planner* by Jongsma).
10. Have the client rate his/her sexual attraction to both men and women on a scale of 1 to 10 (with 10 being extremely attracted and 1 being not at all attracted).
11. Explore with the client how cultural, racial, and/or ethnic factors contribute to confusion about homosexual behavior and/or identity.
12. Assign the client the homework of writing a “future” biography describing his/her life 20 years in the future, once as a heterosexual, another as a homosexual; read and process in session (e.g., ask him/her which life was more satisfying, which life had more regret).
13. Educate the client about the range of sexual identities possible (i.e., heterosexual, homosexual, bisexual).
14. Have the client read *The Invention of Heterosexuality*

- by Katz; process the client's thoughts and feelings about its content.
8. Identify the negative emotions experienced by hiding sexuality. (15, 16)
 9. Verbalize an understanding of safer-sex practices. (17)
 10. Verbalize an increased understanding of homosexuality. (13, 18, 19)
 11. List the advantages and disadvantages of disclosing
 15. Explore the client's negative emotions (e.g., shame, guilt, anxiety, loneliness) related to hiding/denying his/her sexuality.
 16. Explore the client's religious convictions and how these may conflict with identifying himself/herself as homosexual and cause feelings of shame or guilt (see the Spiritual Confusion chapter in this Planner); consider suggesting that the client read *The Bible, Christianity, & Homosexuality* by Cannon that argues the Bible does not condemn faithful gay relationships.
 17. Teach the client the details of safer-sex guidelines and encourage him/her to include them in all future sexual activity.
 13. Educate the client about the range of sexual identities possible (i.e., heterosexual, homosexual, bisexual).
 18. Assign the client homework to identify 10 myths about homosexuals and assist him/her in replacing them with more realistic, positive beliefs.
 19. Assign the client to read books that provide accurate, positive messages about homosexuality (e.g., *Is it a Choice?* by Marcus; *Outing Yourself* by Signorile; *Coming Out: An Act of Love* by Eichberg).
 20. Assign the client to list advantages and disadvantages of

- sexual orientation to significant people in life. (20)
- disclosing sexual orientation to significant others; process the list content.
12. Watch films/videos that depict lesbian women/gay men in positive ways. (21)
 21. Ask the client to watch movies/videos that depict lesbians/gay men as healthy and happy (e.g., *Desert Hearts*; *In and Out*; *Jeffrey*; *When Night is Falling*); process his/her reactions to the films.
 13. Attend a support group for those who want to disclose themselves as homosexual. (22)
 22. Refer the client to a coming out support group (e.g., at Gay and Lesbian Community Service Center or AIDS Project).
 14. Identify gay/lesbian people to socialize with or to obtain support from. (23, 24, 25)
 23. Assign the client to read lesbian/gay magazines and newspapers (e.g., *The Advocate*).
 24. Encourage the client to gather information and support from the Internet (e.g., coming-out bulletin boards on AOL and Facebook, lesbian/gay organizations' web sites).
 25. Encourage the client to identify gay men or lesbians to interact with by reviewing people he/she has met in support groups, at work, and so on, and encourage him/her to initiate social activities.
 15. Develop a plan detailing when, where, how, and to whom sexual orientation is to be disclosed. (26, 27)
 26. Have the client role-play disclosure of sexual orientation to significant others (e.g., family, friends, coworkers; see the Family Conflict chapter in this *Planner*).
 27. Assign the client homework to write a detailed plan to disclose his/her sexual orientation, including to whom it will be disclosed, where, when, and possible questions and reactions

recipient(s) might have (or assign “To Whom and How to Reveal My Homosexuality” from the *Adult Psychotherapy Homework Planner* by Jongsma).

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| <p>16. Identify one friend who is likely to have a positive reaction to homosexuality disclosure. (28, 29)</p> | <p>28. Encourage the client to identify one friend who is likely to be accepting of his/her homosexuality.</p> |
| <p>17. Reveal sexual orientation to significant others according to written plan. (30, 31)</p> | <p>29. Suggest the client have casual talks with a friend about lesbian/gay rights, or some item in the news related to lesbians and gay men to “test the water” before disclosing sexual orientation to that friend.</p> |
| | <p>30. Encourage the client to disclose sexual orientation to friends/family according to the written plan.</p> |
| | <p>31. Probe the client about reactions of significant others to disclosure of homosexuality (e.g., acceptance, rejection, shock); provide encouragement and positive feedback.</p> |

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	309.0	Adjustment Disorder With Depressed Mood
	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood

	309.24	Adjustment Disorder With Anxiety
	300.4	Dysthymic Disorder
	302.85	Gender Identity Disorder in Adolescents or Adults
	300.02	Generalized Anxiety Disorder
	313.82	Identity Problem
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	302.9	Sexual Disorder NOS
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Axis II:	301.82	Avoidant Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.28	F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
309.24	F43.22	Adjustment Disorder, With Anxiety
300.4	F34.1	Persistent Depressive Disorder
302.85	F64.1	Gender Dysphoria in Adolescents and Adults
300.02	F41.1	Generalized Anxiety Disorder
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
301.82	F60.6	Avoidant Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

SLEEP DISTURBANCE

BEHAVIORAL DEFINITIONS

1. Complains of difficulty falling asleep.
2. Complains of difficulty remaining asleep.
3. Reports sleeping adequately, but not feeling refreshed or rested after waking.
4. Exhibits daytime sleepiness or falling asleep too easily during daytime.
5. Insomnia or hypersomnia complaints due to a reversal of the normal sleep-wake schedule.
6. Reports distress resulting from repeated awakening with detailed recall of extremely frightening dreams involving threats to self.
7. Experiences abrupt awakening with a panicky scream followed by intense anxiety and autonomic arousal, no detailed dream recall, and confusion or disorientation.
8. Others report repeated incidents of sleepwalking accompanied by amnesia for the episode.

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LONG-TERM GOALS

1. Restore restful sleep pattern.
2. Feel refreshed and energetic during wakeful hours.
3. Terminate anxiety-producing dreams that cause awakening.

4. End abrupt awakening in terror and return to peaceful, restful sleep pattern.
5. Restore restful sleep with reduction of sleepwalking incidents.

SHORT-TERM OBJECTIVES

1. Describe the history and details of sleep pattern. (1, 2)
2. Share history of substance abuse or medication use. (3)
3. Verbalize depressive or anxious feelings and share possible causes. (4)

THERAPEUTIC INTERVENTIONS

1. Assess the client's sleep history including sleep pattern, bedtime routine, activities associated with the bed, activity level while awake, nutritional habits including stimulant use, napping practice, actual sleep time, rhythm of time for being awake versus sleeping, and so on.
2. Assign the client to keep a journal of sleep patterns, stressors, thoughts, feelings, and activities associated with going to bed, and other relevant client-specific factors possibly associated with sleep problems; process the material for details of the sleep-wake cycle.
3. Assess the contribution of the client's medication or substance abuse to his/her sleep disorder; refer him/her for chemical dependence treatment, if indicated (see the Substance Use chapter in this *Planner*).
4. Assess the role of depression or anxiety as the cause of the client's sleep disturbance (see the

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, Unipolar Depression or Anxiety chapters in this *Planner*).

- vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼^{EB} 5. Keep physician appointment to assess possible medical contributions to sleep disorder and the need for psychotropic medications. (9)
 - ▼^{EB} 6. Take psychotropic medication as prescribed to assess the effect on sleep. (10)
 - ▼^{EB} 7. Verbalize an understanding of normal sleep, sleep disturbances, and their treatment. (11, 12, 13)
 9. Refer the client to a physician to rule out medical or pharmacological causes for sleep disturbance and to consider sleep lab studies and/or need for a prescription of psychotropic medications. ▼^{EB}
 10. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects. ▼^{EB}
 11. Provide the client with basic sleep education (e.g., normal length of sleep, normal variations of sleep, normal time to fall asleep, and normal mid-night awakening; recommend *The Insomnia Workbook: A Comprehensive Guide to Getting the Sleep You Need* by Silberman); help the client understand the exact nature of his/her “abnormal” sleeping pattern. ▼^{EB}
 12. Provide the client with a rationale for the therapy, explaining the role of cognitive, emotional, physiological, and behavioral contributions to good and poor sleep. ▼^{EB}
 13. Ask the client to read material consistent with the therapeutic approach to facilitate his/her progress through therapy

(e.g., *Say Good Night to Insomnia* by Jacobs; *The Harvard Medical School Guide to a Good Night's Sleep* by Epstein and Mardon).^{EB}

- ^{EB} 8. Learn and implement calming skills for use at bedtime. (14, 15)
- ^{EB} 9. Practice good sleep hygiene. (16)
- ^{EB} 10. Learn and implement stimulus control strategies to establish a consistent sleep-wake rhythm. (17, 18, 19, 20)
14. Teach the client relaxation skills (e.g., progressive muscle relaxation, guided imagery, slow diaphragmatic breathing); teach the client how to apply these skills to facilitate relaxation and sleep at bedtime (see “Bedtime Relaxation Techniques” by Hauri and Linde).^{EB}
15. Refer the client for or conduct biofeedback training to strengthen the client’s successful relaxation response.^{EB}
16. Instruct the client in sleep hygiene practices such as restricting excessive liquid intake, spicy late night snacks, or heavy evening meals; exercising regularly, but not within 3–4 hours of bedtime; minimizing or avoiding caffeine, alcohol, tobacco, and stimulant intake (or assign “Sleep Pattern Record” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}
17. Discuss with the client the rationale for stimulus control strategies to establish a consistent sleep-wake cycle (see *Behavioral Treatments for Sleep Disorders* by Perlis, Aloia, and Kuhn).^{EB}
18. Teach the client stimulus control techniques (e.g., lie down to sleep only when sleepy; do not use the bed for activities like watching television, reading, listening to music, but only for

sleep or sexual activity; get out of bed if sleep doesn't arrive soon after retiring; lie back down when sleepy; set alarm to the same wake-up time every morning regardless of sleep time or quality; do not nap during the day); assign consistent implementation. ▽

19. Instruct the client to move activities associated with arousal and activation from the bedtime ritual to other times during the day (e.g., reading stimulating content, reviewing day's events, planning for next day, watching disturbing television). ▽
 20. Monitor the client's sleep patterns and compliance with stimulus control instructions; problem-solve obstacles and reinforce successful, consistent implementation. ▽
 21. Use a sleep restriction therapy approach in which the amount of time in bed is reduced to match the amount of time the patient typically sleeps (e.g., from 8 hours to 5), thus inducing systematic sleep deprivation; periodically adjust sleep time upward until an optimal sleep duration is reached. ▽
 22. Explore the client's schema and self-talk that mediate his/her emotional responses counterproductive to sleep (e.g., fears, worries of sleeplessness), challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase the likelihood of establishing a sound sleep pattern
- ▽ 11. Learn and implement a sleep restriction method to increase sleep efficiency. (21)
- ▽ 12. Identify, challenge, and replace self-talk contributing to sleep disturbance with positive, realistic, and reassuring self-talk. (22, 23)

(see *Insomnia: A Clinical Guide to Assessment and Treatment* by Morin and Espie). ▾

- ▾ 13. Implement a paradoxical instruction to stay awake as a means to counter anxiety interfering with sleep onset. (24)
- ▾ 14. Learn and implement skills for managing stresses contributing to the sleep problem. (25)
23. Assign the client a homework exercise in which he/she identifies targeted self-talk and creates reality-based alternatives (or assign “Negative Thoughts Trigger Negative Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. ▾
24. Assign a paradoxical intervention in which the client tries to stay awake for as long as possible to diminish performance anxiety interfering with sleep; review implementation, reinforcing success; problem-solve obstacles. ▾
25. Use cognitive behavioral skills training techniques (e.g., instruction, covert modeling [i.e., imagining the successful use of the strategies], role-play, practice, and generalization training) to teach the client tailored skills (e.g., calming and coping skills, conflict-resolution, problem-solving) for managing stressors related to the sleep disturbance (e.g., interpersonal conflicts that carry over and cause nighttime wakefulness); routinely review, reinforce successes, problem-solve obstacles toward effective everyday use (see *Insomnia: A Clinical Guide to Assessment and Treatment* by Morin and Espie; *Treating Sleep Disorders* by Goetting, Perlis and Lichstein). ▾

- ▽^{EB} 15. Verbalize an understanding of the cognitive-behavioral approach to treating sleeplessness. (26)
16. Participate in a scheduled awakening procedure to reduce the frequency of night waking. (27)
17. Learn and implement relapse prevention practices. (28, 29, 30, 31, 32)
26. Assign the client to read material on the cognitive-behavioral treatment approach to sleeplessness (e.g., *Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach Workbook* by Edinger and Carney; *Say Good Night to Insomnia* by Jacobs).▽^{EB}
27. Use a scheduled awakening procedure in which the client is gently and only slightly awakened 30 minutes prior to the typical time of the first night waking, sleep terror, or sleepwalking incident; phase out the awakening as sleep terrors decrease (see *When Children Don't Sleep Well* by Durand).
28. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an occasional and reversible slip into old habits and relapse with the decision to return to old habits that risk sleep disturbance (e.g., poor sleep hygiene, poor stimulus control practices).
29. Identify and rehearse with the client the management of future lapses.
30. Instruct the client to routinely use strategies learned in therapy (e.g., good sleep hygiene and stimulus control) to prevent relapse into habits associated with sleep disturbance.
31. Develop a “coping card” or other reminder where relapse prevention practices are recorded for the client’s later use.
32. Schedule periodic “maintenance sessions” to help the client maintain therapeutic gains.

- 18. Discuss experiences of emotional traumas that may disturb sleep. (33)
- 19. Discuss fears regarding relinquishing control. (34)
- 20. Disclose fears of death that may contribute to sleep disturbance. (35)
- 21. Share childhood traumatic experiences associated with sleep experience. (36, 37)
- 22. Reveal sexual abuse incidents that continue to be disturbing. (38)
- 23. _____
- 24. _____
- 25. _____
- 26. _____
- 27. _____
- 28. _____
- 29. _____
- 30. _____
- 31. _____
- 32. _____
- 33. Explore recent traumatic events that may be interfering with the client's sleep.
- 34. Probe the client's fears related to letting go of control.
- 35. Probe a fear of death that may contribute to the client's sleep disturbance.
- 36. Explore traumas of the client's childhood that surround the sleep experience.
- 37. Probe the client for the presence and nature of disturbing dreams and explore their possible relationship to present or past trauma.
- 38. Explore for possible sexual abuse to the client that has not been revealed (see the Sexual Abuse Victim chapter in this *Planner*).

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.42	Primary Insomnia
	307.44	Primary Hypersomnia
	307.45	Circadian Rhythm Sleep Disorder
	307.47	Nightmare Disorder
	307.46	Sleep Terror Disorder
	307.46	Sleepwalking Disorder
	309.81	Posttraumatic Stress Disorder

296.xx	Major Depressive Disorder
300.4	Dysthymic Disorder

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
307.42	G47.00	Insomnia
307.44	G47.10	Hypersomnolence Disorder
307.45	G47.xx	Circadian Rhythm Sleep-Wake Disorder
307.47	F51.5	Nightmare Disorder
307.46	F51.4	Non-Rapid Eye Movement Sleep Arousal Disorder, Sleep Terror Type
307.46	F51.3	Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking Type
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and DSM-5 Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

SOCIAL ANXIETY

BEHAVIORAL DEFINITIONS

1. Overall pattern of social anxiety, shyness, or timidity that presents itself in most social situations.
2. Hypersensitivity to the criticism or disapproval of others.
3. No close friends or confidants outside of first-degree relatives.
4. Avoidance of situations that require a degree of interpersonal contact.
5. Reluctant involvement in social situations out of fear of saying or doing something foolish or of becoming emotional in front of others.
6. Debilitating performance anxiety and/or avoidance of required social performance demands.
7. Increased heart rate, sweating, dry mouth, muscle tension, and shakiness in social situations.

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LONG-TERM GOALS

1. Interact socially without undue fear or anxiety.
2. Participate in social performance requirements without undue fear or anxiety.
3. Develop the essential social skills that will enhance the quality of relationship life.
4. Develop the ability to form relationships that will enhance recovery support system.

5. Reach a personal balance between solitary time and interpersonal interaction with others.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Describe the history and nature of social fears and avoidance. (1, 2) 2. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (3) 3. Disclose any history of substance use that may contribute to and complicate the treatment of social anxiety. (4) | <ol style="list-style-type: none"> 1. Establish rapport with the client toward building a therapeutic alliance. 2. Assess the client’s history of social anxiety and avoidance including frequency, intensity, and duration of anxiety symptoms, triggers, and the nature and extent of avoidance (e.g., <i>The Anxiety Disorders Interview Schedule–Adult Version</i>). 3. Administer a measure of social anxiety to further assess the depth and breadth of social fears and avoidance (e.g., the <i>Liebowitz Social Anxiety Scale</i>; <i>Social Interaction Anxiety Scale</i>; <i>Social Phobia Inventory</i>); readminister as indicated to assess treatment progress. 4. Arrange for a substance abuse evaluation and refer the client for treatment for if the evaluation recommends it (see the Substance Use chapter in this <i>Planner</i>). |
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4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as

- well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼^{EB} 5. Cooperate with an evaluation by a physician for psychotropic medication. (9)
 - ▼^{EB} 6. Take prescribed psychotropic medications consistently. (10)
 - ▼^{EB} 7. Participate in a small group therapy for social anxiety. (11)
 - ▼^{EB} 8. Verbalize an accurate understanding of the vicious cycle of social anxiety and avoidance. (12, 13)
 9. Arrange for the client to have an evaluation for a prescription of psychotropic medications. ▼^{EB}
 10. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. ▼^{EB}
 11. Enroll client in a small (closed enrollment) cognitive-behavioral group therapy for social anxiety (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; *Social Anxiety Disorder* by Turk, Heimberg, and Magee). ▼^{EB}
 12. Discuss how social anxiety derives from cognitive biases that overestimate negative evaluation by others, undervalue the self, distress, and often lead to unnecessary avoidance. ▼^{EB}
 13. Assign the client to read psychoeducational chapters of books or treatment manuals on social anxiety that explain the cycle of social anxiety and avoidance and the rationale for cognitive behavioral treatment (e.g., *Overcoming Social Anxiety and Shyness* by Butler; *The Shyness and Social Anxiety Workbook* by Antony and Swinson; *Managing Social Anxiety* by Hope, Heimberg, and Turk). ▼^{EB}

- ▼^{EB} 9. Verbalize an understanding of the rationale for cognitive-behavioral treatment of social anxiety. (14)
- ▼^{EB} 10. Learn and implement calming and coping strategies to manage anxiety symptoms during moments of social anxiety and lead to a more relaxed state in general. (15)
- ▼^{EB} 11. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (16, 17)
14. Discuss how therapy based on cognitive-behavioral principles targets fear and avoidance to desensitize learned fear, build social skills, reality-test anxious thoughts, and increase confidence and social effectiveness. ▼^{EB}
15. Teach and ask the client to practice relaxation and attentional focusing skills (e.g., staying focused externally and on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, ride the wave of anxiety) for managing social anxiety symptoms and maintaining a more relaxed approach to life; review, reinforce successes; provide corrective feedback toward effective use. ▼^{EB}
16. Explore the client's and self-talk and underlying beliefs that mediate his/her social fears, challenge the biases (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); assist him/her in generating appraisals that correct for the biases and build confidence. ▼^{EB}
17. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; test fear-based predictions against alternatives using behavioral experiments; review; reinforce success, problem-solve obstacles toward accomplishing objective (see "Restoring Socialization Comfort" in the *Adult*

Psychotherapy Homework Planner by Jongsma; *The Shyness and Social Anxiety Workbook* by Antony and Swinson). ▽

- ▽ 12. Participate in gradual repeated exposure to feared social situations within and outside of therapy. (18, 19, 20)
18. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response. ▽
19. Select initial in vivo or role-played exposures that have a high likelihood of being a successful experience for the client; do cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate progress through the hierarchy (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; *Managing Social Anxiety* by Hope, Heimberg, and Turk). ▽
20. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (or assign “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma; also see *The Shyness and Social Anxiety Workbook* by Antony and Swinson; review and reinforce success, providing corrective feedback toward improvement. ▽
- ▽ 13. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (21, 22)
21. Use instruction, modeling, and role-playing to build the client’s general social and/or communication skills (*Cognitive Behavioral Group Therapy for Social Phobia* by Heimberg

- and Becker; *Managing Social Anxiety* by Hope, Heimberg, and Turk).^{EB}▽
22. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Con conversationally Speaking* by Garner).^{EB}▽
- ▽^{EB} 14. Implement relapse prevention strategies for managing possible future anxiety symptoms. (23, 24, 25, 26)
23. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.^{EB}▽
24. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.^{EB}▽
25. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships.^{EB}▽
26. Develop a “coping card” on which coping strategies and other important information (e.g., “Pace your breathing,” “Focus on the task at hand,” “You can manage it,” and “It will go away”) are recorded for the client’s later use.^{EB}▽
15. Participate in Acceptance and Commitment Therapy (ACT) for social anxiety. (27, 28, 29, 30)
27. Use an ACT approach to help the client accept and openly experience anxious thoughts and feelings without being overly impacted by them, and committing his/her time and

- efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).
28. Teach mindfulness meditation to help the client recognize the negative thought processes associated with social anxiety and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
 29. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into in everyday life.
 30. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
 16. Identify important people in life, past and present, and describe the quality, good and poor, of those relationships. (31)
 31. Conduct Interpersonal Therapy (apply *Comprehensive Guide to Interpersonal Psychotherapy* by Weissman, Markowitz, and Klerman) beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships; develop a case formulation linking social anxiety grief, interpersonal role disputes, role transitions, and/or interpersonal deficits).

17. Verbalize and demonstrate an understanding and resolution of current interpersonal problems. (32, 33, 34, 35)
18. Explore past experiences that may be the source of low self-esteem and social anxiety currently. (36, 37)
19. Work through developmental conflicts that may be influencing current struggles with fear and
32. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.
33. For interpersonal disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.
34. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role, and taking steps to gain mastery over the new role.
35. For interpersonal deficits, help the client develop new interpersonal skills and relationships.
36. Probe childhood experiences of criticism, abandonment, or abuse that would foster low self-esteem and shame; process these.
37. Assign the client to read the books *Healing the Shame That Binds You* by Bradshaw and *Facing Shame* by Fossum and Mason, and process key ideas.
38. Use an insight-oriented approach to explore how psychodynamic conflicts

avoidance and take appropriate actions. (38)

(e.g., separation/autonomy; anger recognition, management, and coping) may be manifesting as social fear and avoidance; address transference; work through separation and anger themes during therapy and upon termination toward developing a new ability to manage separations and autonomy.

20. Verbally describe the defense mechanisms used to avoid close relationships. (39)

39. Assist the client in identifying defense mechanisms that keep others at a distance and prevent him/her from developing trusting relationships; identify ways to minimize defensiveness.

21. Return for a follow-up session to track progress, reinforce gains, and problem-solve barriers. (40)

40. Schedule a follow-up or “booster session” for the client for 1 to 3 months after therapy ends to track progress.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:


Axis I:	300.23	Social Phobia
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.7	Body Dysmorphic Disorder
	_____	_____
	_____	_____

Axis II:	301.82	Avoidant Personality Disorder
	301.0	Paranoid Personality Disorder
	310.22	Schizotypal Personality Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.7	F45.22	Body Dysmorphic Disorder
301.82	F60.6	Avoidant Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
310.22	F21	Schizotypal Personality Disorder
301.20	F60.1	Schizoid Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

SOMATIZATION

BEHAVIORAL DEFINITIONS

1. Complains of a physical malady that seems to be caused by a psychosocial stressor triggering a psychological conflict.
2. Preoccupied with the fear of having serious physical disease, without any medical basis for concern.
3. Exhibits a multitude of physical complaints that have no organic foundation but have led to life changes (e.g., seeing doctors often, taking prescriptions, withdrawing from responsibilities).
4. Preoccupied with chronic pain beyond what is expected for a physical malady or in spite of no known organic cause.
5. Complains of one or more physical problems (usually vague) that have no known organic basis, resulting in impairment in life functioning in excess of what is expected.
6. Preoccupied with pain in one or more anatomical sites with both psychological factors and a medical condition as a basis for the pain.
7. Preoccupied with an imagined physical defect in appearance or a vastly exaggerated concern about a minimal defect (Body Dysmorphic Disorder).

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LONG-TERM GOALS

1. Reduce frequency of physical complaints and improve the level of independent functioning.
2. Reduce verbalizations focusing on pain while increasing productive activities.
3. Accept body appearance as normal even with insignificant flaws.
4. Accept self as relatively healthy with no known medical illness or defects.
5. Improve physical functioning due to development of adequate coping mechanisms for stress management.

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SHORT-TERM OBJECTIVES

1. Verbalize health concerns and/or negative feelings regarding body as well as feared consequences of perceived body abnormality. (1, 2, 3)
2. Complete psychological tests designed to assess the depth and breadth of the presenting problem(s). (4)

THERAPEUTIC INTERVENTIONS

1. Build a level of trust and understanding with the client by listening to his/her initial complaints without rejection or confrontation.
2. Nurture a trusting relationship throughout therapy by not dismissing or trivializing health complaints while simultaneously advancing a psychosocial treatment approach.
3. Assess the history of the client's complaints including symptoms, fears, effect on functioning, stressors, and goals of treatment.
4. Administer surveys tailored to the presenting complaint to assess its nature and severity (e.g., *the Body Dysmorphic*

Disorder Examination; the Whiteley Index; the Illness Attitude Scale for health anxiety); discuss results with client; readminister as needed to assess progress.

3. Disclose any history of substance use that may contribute to and complicate the treatment of somatization. (5)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better

understanding of the client's behavior.

9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 10. Arrange for the client to have an evaluation by a physician for a prescription of psychotropic medications (e.g., SSRIs).^{EB}
 11. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.^{EB}
 12. Use a cognitive-behavioral/Stress Inoculation Training approach to help the client conceptualize the stress-somatization relationship and learn and implement tailored skills (e.g., calming and coping skills, communication, problem-solving, exposure) for managing stressors, decreasing fears, overcoming avoidance, and increasing present-day adaptation through problem-focused coping (see *Stress Inoculation Training* by Meichenbaum; *Treating Health*
5. Cooperate with an evaluation by a physician for psychotropic medication. (10)^{EB}
 6. Take psychotropic medications consistently. (11)^{EB}
 7. Participate in individual or group Cognitive-Behavioral Therapy. (12)^{EB}

Anxiety by Taylor and Asmundson; *Body Dysmorphic Disorder* by Veale and Neziroglu).^{EB}▽

- ▽^{EB} 8. Verbalize an understanding of the rationale for treatment. (13)
- ▽^{EB} 9. Identify and replace biased, fearful self-talk and beliefs with realistic, accepting self-talk and beliefs. (14, 15)
13. Educate the client, with sensitivity to defensiveness, about the role of biased fears and avoidance in maintaining the disorder; about the role of stress in exacerbating symptoms; discuss how treatment serves as an arena to desensitize fears, to reality-test fears and underlying beliefs, build skills in managing stress, and build confidence and self-acceptance regarding appearance, health, and/or other concerns.^{EB}▽
14. Use Cognitive Restructuring techniques to explore the client's self-talk and underlying beliefs that mediate his/her fears and related avoidance or reassurance seeking (e.g., "I have never been a healthy person," "These sensations indicate a problem," "My receding hairline is repulsive"); assist him/her in generating thoughts that challenge and correct for the biases (see *Treating Health Anxiety* by Taylor and Asmundson; assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
15. Conduct behavioral experiments that repeatedly test biased and alternative beliefs; review; reinforce successes; problem-solve obstacles toward a shift in fearful beliefs.^{EB}▽

- ▽^{EB} 10. Discuss current stresses that may influence physical complaints. (16)
- ▽^{EB} 11. Participate in repeated imaginal and/or live exposure to feared external and/or internal cues. (17, 18, 19)
- ▽^{EB} 12. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (20, 21, 22)
16. Discuss how stress may be exacerbating the focus and/or experience of physical symptoms to a degree that the client can accept it and provide a rationale for learning personalized stress management skills. ▽^{EB}
17. Assess external triggers for fears (e.g., persons, situations, sensations) and subtle and obvious avoidant strategies (e.g., wearing concealing clothing for BDD, reassurance-seeking for hypochondriasis). ▽^{EB}
18. Direct and assist the client in construction of a hierarchy of fear triggers; incorporate exposures that gradually increase the client to what he/she fears while reducing subtle and obvious avoidant habits. ▽^{EB}
19. Select initial exposures that have a high likelihood of being a successful experience for the client; be a participant model, do cognitive restructuring within and after the exposure; incorporate response prevention if needed (e.g., asking the client with BDD to refrain from concealing the undesirable physical feature, agreeing not to seek reassurance; adhering to a reasonable schedule of medical evaluations). ▽^{EB}
20. Teach the client calming/relaxation skills (e.g., applied relaxation, progressive muscle relaxation, cue controlled relaxation; mindful breathing; biofeedback) and how to discriminate better between relaxation and tension; teach the

client how to apply these skills to his/her daily life (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec; *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay). ▽

21. Assign the client homework each session in which he/she practices relaxation exercises daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success while providing corrective feedback toward improvement. ▽
 22. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow). ▽
 23. Teach the client problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating the pros and cons of each option, selecting and implementing an optional action, and re-evaluating and refining the action (or assign “Plan Before Acting” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
 24. Assign the client homework exercises in which he/she strengthens new skills through repeated exposures between sessions while recording
- ▽ 13. Learn and implement problem-solving strategies for realistically addressing worries. (23)
 - ▽ 14. Complete homework assignments involving exposure to feared external and/or internal cues. (24)

- responses (or assign “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma); review during next session, reinforcing success and problem-solving obstacles toward improvement. ^{EB}▽
- ▽^{EB} 15. Implement the use of the “thought-stopping” technique to reduce the frequency of obsessive thoughts. (25, 26)
25. Teach the client to interrupt critical self-conscious thoughts using the “thought-stopping” technique of shouting “STOP” to himself/herself silently while picturing a red traffic signal and then thinking about a calming scene. ^{EB}▽
26. Assign the client to implement the “thought-stopping” technique on a daily basis between sessions (or assign “Making Use of the Thought-Stopping Technique” in the *Adult Psychotherapy Homework Planner* by Jongsma); review. ^{EB}▽
- ▽^{EB} 16. Express thoughts and feelings assertively and directly. (27, 28, 29)
27. Using instruction, role-playing, and behavioral rehearsal, teach the client assertive, respectful expression of thoughts and feelings. ^{EB}▽
28. Train the client in assertiveness or refer him/her to an assertiveness training class (recommend *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships* by Alberti and Emmons). ^{EB}▽
29. Reinforce the client’s assertiveness as a means of him/her attaining healthy need satisfaction in contrast to passive helplessness. ^{EB}▽
- ▽^{EB} 17. Learn and implement guided self-dialogue to manage
30. Teach the client a guided self-dialogue procedure in which

thoughts, feelings, and urges brought on by encounters with trauma-related situations. (30)

he/she learns to recognize maladaptive self-talk, challenges its biases, copes with engendered feelings, overcomes avoidance, and reinforces his/her accomplishments; review and reinforce progress, problem-solve obstacles toward developing an effective consolidated approach. ▽

18. Learn about health/appearance anxiety through completion of prescribed reading. (31)
19. Implement maintenance strategies for managing possible future lapses. (32, 33, 34, 35)
31. Assign the client who has accepted the role of anxiety in their health/appearance concerns to read about health anxiety in self-help books consistent with the therapeutic model (e.g., *Stop Worrying About Your Health* by Zgourides; *The BDD Workbook* by Claiborne and Pedrick; *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook* by Otis).
32. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern thinking, feeling, and behaving that is characteristic of the disorder.
33. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.
34. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previously feared external or internal cues that arise) to prevent lapses into former patterns of internal focus on physical complaints, self-conscious fears, and/or avoidance patterns.

20. Discuss causes for emotional stress in life that underlie the focus on physical complaints. (36, 37, 38)
21. Identify family patterns that exist around exaggerated focus on physical maladies. (39)
22. Verbalize the secondary gain that results from physical complaints. (40)
23. Participate in Acceptance and Commitment Therapy (ACT) for health/appearance worries. (41, 42, 43)
35. Schedule periodic “maintenance sessions” to help the client maintain therapeutic gains.
36. Refocus the client’s discussion from physical complaints to emotional conflicts and expression of feelings.
37. Explore the client’s sources of emotional pain—feelings of fear, inadequacy, rejection, or abuse.
38. Assist the client in acceptance of connection between physical focus and avoidance of facing emotional conflicts.
39. Explore the client’s family history for modeling and reinforcement of physical complaints.
40. Assist the client in developing insight into the secondary gain received from physical illness, complaints, and the like.
41. Use an ACT approach to help the client experience and accept the presence of worrisome thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
42. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while

- noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
24. Increase social and productive activities rather than being preoccupied with self and physical complaints. (44, 45)
 25. Decrease physical complaints, doctor visits, and reliance on medication while increasing verbal assessment of self as able to function normally and productively. (46, 47)
 43. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life (or assign *Living Beyond Your Pain: Using Acceptance and Commitment Therapy to Ease Chronic Pain* by Dahl and Lundgren).
 44. Assist the client in developing a list of pleasurable activities that can serve as rewards and diversions from bodily focus (or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 45. Assign diversion activities that take the client’s focus off himself/herself and redirect it toward hobbies, social activities, assisting others, completing projects, or returning to work.
 46. Challenge the client to endure pain and carry on with responsibilities so as to build self-esteem and a sense of contribution.
 47. Structure specific times each day for the client to think about, talk about, and write down his/her physical problems while outside of those times the client will not focus on his/her physical condition; monitor and process the intervention’s effectiveness (or assign “Controlling the

Focus on Physical Problems”
in the *Adult Psychotherapy
Homework Planner* by Jongsma).

- 26. Engage in normal responsibilities vocationally and socially without complaining or withdrawing into avoidance while using physical problems as an excuse. (48, 49)
- 27. Make and attend an appointment at a pain clinic. (50)
- 48. Give positive feedback when the client is not focusing on and talking about symptoms but is accepting of his/her body as normal and is performing daily work, family, and social activities without avoidance or excuse.
- 49. Discuss with the client the destructive social impact that consistent complaining and/or negative body focus have on relationships with friends and family; ask him/her to reflect on this and recall how others have reacted negatively to complaints.
- 50. Refer the client to a pain clinic to learn pain management techniques.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.7	Body Dysmorphic Disorder
	300.11	Conversion Disorder
	300.7	Hypochondriasis
	300.81	Somatization Disorder
	307.80	Pain Disorder Associated With Psychological Factors

307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
300.81	Undifferentiated Somatoform Disorder
300.4	Dysthymic Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.7	F45.22	Body Dysmorphic Disorder
300.11	F44.x	Conversion Disorder
300.7	F45.21	Illness Anxiety Disorder
300.81	F45.1	Somatic Symptom Disorder
307.80	F45.1	Somatic Symptom Disorder, With Predominant Pain
307.89	F54	Psychological Factors Affecting Other Medical Conditions
300.4	F34.1	Persistent Depressive Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

SPIRITUAL CONFUSION

BEHAVIORAL DEFINITIONS

1. Verbalization of a desire for a closer relationship to a higher power.
2. Feelings and attitudes about a higher power that are characterized by fear, anger, and distrust.
3. Verbalization of a feeling of emptiness in his/her life, as if something was missing.
4. A negative, bleak outlook on life and regarding others.
5. A felt need for a higher power, but because upbringing contained no religious education or training, does not know where or how to begin.
6. An inability to connect with a higher power due to anger, hurt, and rejection from religious upbringing.
7. A struggle with understanding and accepting Alcoholics Anonymous (AA) Steps Two and Three (i.e., difficulty in believing in a higher power).

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LONG-TERM GOALS

1. Clarify spiritual concepts and instill a freedom to approach a higher power as a resource for support.
2. Increase belief in and development of a relationship with a higher power.
3. Begin a faith in a higher power and incorporate it into support system.
4. Resolve issues that have prevented faith or belief from developing and growing.

SHORT-TERM OBJECTIVES

1. Summarize the highlights of own spiritual quest or journey to this date. (1)
2. Describe beliefs and feelings around the idea of a higher power. (2, 3, 4)
3. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

THERAPEUTIC INTERVENTIONS

1. Ask the client to talk about or write the story of his/her spiritual quest/journey (or assign “My History of Spirituality” from the *Adult Psychotherapy Homework Planner* by Jongsma); process the journey material.
2. Assign the client to list all of his/her beliefs related to a higher power; process the beliefs.
3. Assist the client in processing and clarifying his/her feelings regarding a higher power.
4. Explore the causes for the emotional components (e.g., fear, rejection, peace, acceptance, abandonment) of the client’s reaction to a higher power.
5. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to

- address the issue as a concern; or demonstrates resistance regarding acknowledgement of the “problem described,” is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 9. Review the client’s early life experiences surrounding belief in a higher power and explore how this affects current beliefs.
4. Describe early life training in spiritual concepts and identify its impact on current religious beliefs. (9)

5. Verbalize an increased knowledge and understanding of concept of a higher power. (10, 11)
6. Identify specific blocks to believing in a higher power. (12, 13)
7. Identify the difference between religion and faith. (14)
8. Replace the concept of a higher power as harsh and judgmental with a belief in a higher power as forgiving and loving. (13, 15)
9. Implement daily attempts to be in contact with higher power. (16, 17, 18)
10. Ask the client to talk with a chaplain, pastor, rabbi, or priest regarding the client's spiritual struggles, issues, or questions, and record the feedback.
11. Assign the client to read *The Case for Faith* by Strobel, *Mere Christianity* by Lewis, or *The Case for God* by Armstrong to build knowledge and a concept of a higher power.
12. Assist the client in identifying specific issues or blocks that prevent the development of his/her spirituality.
13. Encourage the client to read books dealing with conversion experiences (e.g., *Surprised by Joy* by Lewis; *The Confessions of St. Augustine* by Augustine; *The Seven Storey Mountain* by Merton).
14. Educate the client on the difference between religion and spirituality.
13. Encourage the client to read books dealing with conversion experiences (e.g., *Surprised by Joy* by Lewis; *Confessions of St. Augustine* by Augustine; *The Seven Storey Mountain* by Merton).
15. Emphasize that the higher power is characterized by love and gracious forgiveness for anyone with remorse and who seeks forgiveness.
16. Recommend that the client implement daily meditations and/or prayer; process the experience.

10. Verbalize separation of beliefs and feelings regarding one's earthly father from those regarding a higher power. (19, 20)
11. Acknowledge the need to separate negative past experiences with religious people from the current spiritual evaluation. (21, 22)
12. Verbalize acceptance of forgiveness from a higher power. (23, 24)
13. Ask a respected person who has apparent spiritual depth to serve as a mentor. (25)
17. Assign the client to write a daily note to his/her higher power.
18. Encourage and assist the client in developing and implementing a daily devotional time or other ritual that will foster his/her spiritual growth.
19. Assist the client in comparing his/her beliefs and feelings about his/her earthly father with those about a higher power.
20. Urge separating the feelings and beliefs regarding the earthly father from those regarding a higher power to allow for spiritual growth and maturity.
21. Assist the client in evaluating religious tenets separated from painful emotional experiences with religious people in his/her past.
22. Explore the religious distortions and judgmentalism that the client has been subjected to by others.
23. Ask the client to read *Serenity: A Companion for 12 Step Recovery* by Helmfelt and Fowler—all readings related to AA Steps Two and Three, *The Road Less Traveled* by Peck, or *Shame and Grace: Healing the Shame We Don't Deserve* by Smedes; process the concept of forgiveness.
24. Explore the client's feelings of shame and guilt that led to him/her feeling unworthy before a higher power and others.
25. Help the client find a mentor to guide his/her spiritual development.

- 14. Attend groups dedicated to enriching spirituality. (26, 27)
- 26. Make the client aware of opportunities for spiritual enrichment (e.g., Bible studies, study groups, fellowship groups); process the experiences he/she decides to pursue.
- 15. Read books that focus on furthering a connection with a higher power. (28)
- 27. Suggest that the client attend a spiritual retreat (e.g., *DeColores* or *Course in Miracles*) and report to therapist what the experience was like for him/her and what he/she gained from the experience.
- 28. Ask the client to read books to cultivate his/her spirituality (e.g., *The Cloister Walk* by Norris; *The Purpose-driven Life* by Warren; *The Care of the Soul* by Moore).

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	311	Depressive Disorder NOS
	300.00	Anxiety Disorder NOS
	296.xx	Major Depressive Disorder
	_____	_____
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Using *DSM-5/ICD-9-CM/ICD-10-CM*:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
311	F32.9	Unspecified Depressive Disorder
311	F32.8	Other Specified Depressive Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
V62.89	Z65.8	Religious or Spiritual Problem

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

SUBSTANCE USE

BEHAVIORAL DEFINITIONS

1. Consistently uses alcohol or other mood-altering drugs until high, intoxicated, or passed out.
2. Unable to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Produces blood study results that reflect a pattern of heavy substance use (e.g., elevated liver enzymes).
4. Denies that chemical dependence is a problem despite direct feedback from spouse, relatives, friends, and employers that the use of the substance is negatively affecting him/her and others.
5. Describes amnestic blackouts that occur when abusing alcohol.
6. Continues drug and/or alcohol use despite experiencing persistent or recurring physical, legal, vocational, social, or relationship problems that are directly caused by the use of the substance.
7. Exhibits increased tolerance for the drug as evidenced by the need to use more to become intoxicated or to attain the desired effect.
8. Exhibits physical symptoms (i.e., shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when withdrawing from the substance.
9. Suspends important social, recreational, or occupational activities because they interfere with using the mood-altering drug.
10. Makes a large time investment in activities to obtain the substance, to use it, or to recover from its effects.
11. Consumes mood-altering substances in greater amounts and for longer periods than intended.
12. Continues abuse of a mood-altering chemical after being told by a physician that it is causing health problems.

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LONG-TERM GOALS

1. Accept the fact of chemical dependence and begin to actively participate in a recovery program.
2. Establish a sustained recovery, free from the use of all mood-altering substances.
3. Establish and maintain total abstinence while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances.
5. Withdraw from mood-altering substance, stabilize physically and emotionally, and then establish a supportive recovery plan.
6. Utilize behavioral and cognitive coping skills to help maintain sobriety.

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SHORT-TERM OBJECTIVES

1. Describe the type, amount, frequency, and history of substance abuse. (1)
2. Complete psychological tests designed to assess the nature and severity of substance abuse. (2)

THERAPEUTIC INTERVENTIONS

1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her use, signs and symptoms of use, and negative life consequences (e.g., social, legal, familial, vocational).
2. Administer to the client an objective test of drug and/or alcohol abuse (e.g., the *Addiction*

Severity Index, the *Michigan Alcohol Screening Test*); process the results with the client.

3. Participate in a medical evaluation to assess the effects of chemical dependence. (3)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)
3. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence.
4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

- ▽ 5. Cooperate with an evaluation by a physician for psychotropic medication. (8, 9)
- ▽ 6. Explore and resolve ambivalence associated with commitment to change behaviors related to substance use and addiction. (10, 11, 12, 13)
7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
8. Assess the need for psychotropic medication for any mental/emotional comorbidities, and discuss the use of acamprosate (Campral), naltrexone (Vivitrol), or disulfiram (Antabuse) where applicable to discourage chemical abuse and strengthen recovery. ▽
9. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. ▽
10. Using a nondirective, client-centered, empathic style derived from motivational enhancement therapy (see *Motivational Interviewing* by Miller and Rollnick; *Motivational Interviewing and Enhancement* by DiClemente, Van Orden, and Wright), establish rapport with the client and listen reflectively, asking permission before providing information or advice. ▽

11. Ask the client to make a list of the ways substance abuse has negatively impacted his/her life (e.g., medically, relationally, legally, vocationally, and socially) and the positive impact nonuse may have (or assign “Substance Abuse Negative Impact versus Sobriety’s Positive Impact” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽
 12. Ask open-ended questions to explore the client’s own motivations for change, affirming his/her change-related statements and efforts (see *Substance Abuse Treatment and the Stages of Change* by Connors, Donovan, and DiClemente).^{EB}▽
 13. Elicit recognition of the discrepancy gap between current behavior and desired life goals, reflecting resistance without direct confrontation or argumentation.^{EB}▽
 14. Encourage and support the client’s self-efficacy for change toward the goal of developing an action plan for termination of substance use to which the client is willing to commit.^{EB}▽
 15. Develop an abstinence contract with the client regarding the termination of the use of his/her drug of choice; process client’s feelings related to the commitment.^{EB}▽
 16. Recommend that the client attend AA or NA meetings and report on the impact of the meetings; process messages the client is receiving.^{EB}▽
- ▽^{EB} 7. Commit self to an action plan directed toward termination of substance use. (14, 15)
 - ▽^{EB} 8. Attend Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings as frequently as necessary to support sobriety. (16)

- ▽^{EB} 9. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (17, 18)
- ▽^{EB} 10. Verbalize increased knowledge of alcoholism and the process of recovery. (19, 20)
- ▽^{EB} 11. Verbalize an understanding of factors that can contribute to development of chemical dependence and pose risks for relapse. (21, 22)
17. Discuss the negative effects the client's substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt. ▽^{EB}
18. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends when working Steps 8 and 9 of the AA program. ▽^{EB}
19. Conduct or assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence; ask him/her to identify several key points attained from each didactic and process these points. ▽^{EB}
20. Assign the client to read a workbook describing evidence-based treatment approaches to addiction recovery (e.g., *Overcoming Your Alcohol or Drug Problem* by Daley and Marlatt); use the readings to reinforce key concepts and practices throughout therapy. ▽^{EB}
21. Assess the client's intellectual, personality, and cognitive vulnerabilities, family history, and life stresses that contribute to his/her chemical dependence. ▽^{EB}
22. Facilitate the client's understanding of his/her genetic, personality, social, and family factors, including childhood experiences, that led to the development of chemical dependency and serve as risk factors for relapse. ▽^{EB}

- ▼^{EB} 12. Identify level of happiness in various areas of life. (23)
- ▼^{EB} 13. Develop goals to increase satisfaction and pleasure in unsatisfactory, nondrinking areas of life. (24)
- ▼^{EB} 14. Learn and implement communication and problem-solving skills toward achieving goals. (25, 26, 27, 28, 29)
23. Approaching the client with empathy and genuine caring, administer *The Happiness Scale* (see *A Community Reinforcement Approach to Addiction Treatment* by Meyers and Miller); review results in session. ▼^{EB}
24. Assist the client in defining specific goals and strategies for achieving increased happiness in problematic, nondrinking areas of life, so that the role of alcohol and/or drugs as the major determinant of an individual's happiness is diminished (consider assigning "Setting and Pursuing Goals in Recovery" in the *Addiction Treatment Homework Planner* by Finley and Lenz). ▼^{EB}
25. Using modeling, role-playing and behavioral rehearsal, teach the client communication skills including how to make statements that convey understanding, accepting partial responsibility for problems, and offering to help solve the problem. ▼^{EB}
26. Teach the client problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties' satisfaction with the action, adjust action if necessary); use role-playing to assist the client in applying these steps to life issues to increase happiness (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼^{EB}

- ▼^{EB} 15. Cooperate with exploration of increasing satisfaction in areas of life that can support sobriety such as employment, recreation, and relationships.
(30, 31, 32, 33, 34)
- 27. Teach the client assertiveness skills that can be used to support drink refusal. ▼^{EB}
- 28. Assign the client to read about general social and/or assertiveness skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Con conversationally Speaking* by Garner). ▼^{EB}
- 29. Assign homework to encourage the client to apply the newly learned behavioral skills to achieving the happiness goals identified (see “Applying Problem-Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma); review progress, reinforcing success and redirecting for failure. ▼^{EB}
- 30. Evaluate the role of the client’s living situation in fostering a pattern of chemical dependence; process with the client. ▼^{EB}
- 31. Facilitate development of a plan for the client to change his/her living situation to foster recovery (or assign “Assessing My Needs” in the *Addiction Treatment Homework Planner* by Finley and Lenz); revisit routinely and facilitate toward accomplishing a positive change in living situation. ▼^{EB}
- 32. Teach the client skills necessary for finding a job, keeping a job, and improving satisfaction in a job setting. ▼^{EB}
- 33. Assist the client in identifying new sources of non-drinking

recreation and social friendships, using problem-solving and communication skills to overcome obstacles. ▾

34. Direct conjoint sessions that address and resolve issues with a partner so as to increase the number of pleasant interactions and reduce conflicts. ▾
35. Develop a sobriety contract with the couple that stipulates an agreement to remain abstinent; limits the focus of partner discussions to present day issues, not past hurtful behaviors; identifies the role of AA meetings; and schedules a daily time to share thoughts and feelings. ▾
36. Ask each partner to make a list of pleasurable activities that could be engaged in together to increase positive feelings toward each other (or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the list and assign implementation of one or more activities before the next session. ▾
37. Teach the couple problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties’ satisfaction with the action, adjust action if necessary); role-play the use of these skills applied to real life
- ▾ 16. Participate in behavioral couples therapy designed to increase the non-substance-using partner’s reinforcement of sobriety and to reduce relationship conflict. (35, 36, 37, 38)

issues of conflict for the couple (or assign “Applying Problem-Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma).^{EB}▽

- ▽^{EB} 17. Identify, challenge, and replace destructive, high-risk self-talk with positive, strength-building self-talk. (39, 40, 41)
38. In light of the recovery contract, review the client’s sobriety experience and the couples’ interaction since the last session; address any relationship conflicts, assisting the couple in improving their communication skills (e.g., “I messages,” reflective listening, eye contact, respectful responding, etc.) by using role-play in the session.^{EB}▽
39. Explore the client’s schema and high-risk self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that corrects for the biases and builds resilience.^{EB}▽
40. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign “Negative Thoughts Trigger Negative Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success.^{EB}▽
41. Assign the client a homework exercise in which he/she identifies high-risk self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments (consider assigning “Replacing Fears With Positive Messages” in the *Adult Psychotherapy Homework*

- ▼^{EB} 18. Earn rewards by submitting drug-negative urine samples. (42)
- ▼^{EB} 19. Earn rewards by maintaining attendance in treatment. (43)
20. Participate in EEG biofeedback treatment to reduce fear of bodily sensations that can trigger substance abuse. (44)
- ▼^{EB} 21. Verbalize an understanding of lapse and relapse. (45, 46)
- Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. ▼^{EB}
42. Implement a prize-based contingency management system by rewarding the client with desired prizes starting at the low end of a \$1–100 range and increasing with continued abstinence. ▼^{EB}
43. Implement a prize-based contingency management system by rewarding the client with desired prizes starting at the low end of a \$1–100 range and increasing with continued attendance. ▼^{EB}
44. Administer to the client or refer the client to a certified biofeedback practitioner for training in using EEG relaxation feedback to cope with arousal-related bodily sensations that may trigger substance abuse.
45. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse. ▼^{EB}
46. Evaluate past lapses and prescribe self-monitoring to assess current risk factors for lapses (or assign “Relapse Triggers” in the *Adult Psychotherapy Homework Planner* by Jongsma and/or the *Alcoholism and Drug Abuse Patient Workbook* by Perkinson). ▼^{EB}

- ▼^{EB} 22. Implement relapse prevention strategies for managing possible future situations with high-risk for relapse. (47, 48, 49, 50)
47. Use stimulus control techniques such as avoidance of specific triggers to reduce exposure to high-risk situations. ▼^{EB}
48. Use instruction, modeling, imaginal rehearsal, role-play, and cognitive restructuring to teach the client cognitive-behavioral skills (e.g., relaxation, problem-solving, social and communication skills, recognition and management of rationalization, denial, and apparently irrelevant decisions) for managing urges and other high risk situations. ▼^{EB}
49. Instruct the client to routinely use strategies learned in therapy (e.g., problem-solving, stimulus control, social skills, and assertiveness) while managing high-risk trigger situations (or assign “Aftercare Plan Components” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼^{EB}
50. Supplement relapse prevention work done in session by recommend that the client read material on how to avoid relapse (e.g., *Staying Sober: A Guide to Relapse Prevention* by Gorski and Miller; *The Staying Sober Workbook* by Gorski; *Overcoming Your Alcohol or Drug Problem: Effective Recovery Strategies—Workbook* by Daley and Marlatt). ▼^{EB}

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	305.60	Cocaine Abuse
	304.80	Polysubstance Dependence
	291.2	Alcohol-Induced Persisting Dementia
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	V71.01	Adult Antisocial Behavior
	300.4	Dysthymic Disorder
	312.34	Intermittent Explosive Disorder
	309.81	Posttraumatic Stress Disorder
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence


Axis II:	301.7	Antisocial Personality Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild

291.2	F10.27	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Nonamnesic-Confabulatory Type
291.1	F10.26	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Amnesic-Confabulatory Type
V71.01	Z72.811	Adult Antisocial Behavior
300.4	F34.1	Persistent Depressive Disorder
312.34	F63.81	Intermittent Explosive Disorder
309.81	F43.10	Posttraumatic Stress Disorder
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

SUICIDAL IDEATION

BEHAVIORAL DEFINITIONS

1. Recurrent thoughts of or preoccupation with death.
2. Recurrent or ongoing suicidal ideation without any plans.
3. Ongoing suicidal ideation with a specific plan.
4. Recent suicide attempt.
5. History of suicide attempts that required professional or family/friend intervention on some level (e.g., inpatient, safe house, outpatient, supervision).
6. Positive family history of depression and/or a preoccupation with suicidal thoughts.
7. A bleak, hopeless attitude regarding life coupled with recent life events that support this (e.g., divorce, death of a friend or family member, loss of job).
8. Social withdrawal, lethargy, and apathy coupled with expressions of wanting to die.
9. Sudden change from being depressed to upbeat and at peace, while actions indicate the client is “putting his/her house in order” and there has been no genuine resolution of conflict issues.
10. Engages in self-destructive or dangerous behavior (e.g., chronic drug or alcohol abuse; promiscuity, unprotected sex; reckless driving) that appears to invite death.

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LONG-TERM GOALS

1. Alleviate the suicidal impulses/ideation and return to the highest level of previous daily functioning.
2. Stabilize the suicidal crisis.
3. Placement in an appropriate level of care to safely address the suicidal crisis.
4. Reestablish a sense of hope for self and the future.
5. Cease the perilous lifestyle and resolve the emotional conflicts that underlie the suicidal pattern.

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SHORT-TERM OBJECTIVES

1. State the strength of the suicidal feelings, the frequency of the thoughts, and the detail of the plans. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Assess the client's suicidal risk including the extent of his/her ideation, the presence and feasibility of a plan, past attempts, substance use, availability of means, and family history.
2. Assess and monitor the client's suicidal potential on an ongoing basis.
3. Notify the client's family and significant others of his/her suicidal ideation; ask them to form a 24-hour suicide watch until the crisis subsides.
4. Arrange or conduct psychometric testing to further assess suicidal behavior and/or related conditions (e.g., *The Suicidal Thinking and Behaviors*)

Questionnaire; The Beck Hopelessness Scale; The Reasons for Living Scale); evaluate the results for the client's degree of depression and suicide risk.

2. Disclose any history of substance use that may contribute to and complicate the treatment of suicidal ideation. (5)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better

- understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
 10. Elicit a promise from the client that he/she will initiate contact with the therapist or a helpline if the suicidal urge becomes strong and before any self-injurious behavior.
 11. Provide the client with a "crisis card" with emergency help telephone numbers making help available 24 hours a day.
 12. Develop a plan with the client, identifying what he/she will and won't do when experiencing suicidal thoughts or impulses; encourage the client to be open and honest regarding suicidal urges, reassuring him/her regularly of caring concern by therapist and significant others.
 13. Offer to be available to the client through telephone contact if a life-threatening urge develops.
 14. Encourage the client and/or significant others to remove firearms or other lethal means to
4. Verbalize a promise to contact the therapist or some other emergency helpline if a serious urge to self-harm arises. (10, 11, 12, 13)
 5. Client and/or significant others increase the safety of the home by removing firearms or other

- potentially lethal means to suicide from easy access. (14)
6. Cooperate with hospitalization if the suicidal urge becomes uncontrollable. (15)
 7. Participate in a therapy for an identified emotional problem resulting in suicidal thoughts. (16)
 8. Cooperate with a referral to a physician for an evaluation for antidepressant medication. (17)
 9. Take psychotropic medications as prescribed and report all side effects. (18)
 10. Identify life factors that preceded the suicidal ideation. (19, 20, 21)
 11. Assess the client's understanding of suicide from easy access; process the client's feelings about this prevention measure.
 12. Arrange for hospitalization when the client is judged to be uncontrollably harmful to self; arrange for a hospital legal commitment if necessary to protect the client from harm to himself/herself.
 13. Assess whether suicidality is functionally related to an active clinical syndrome (e.g., unipolar or bipolar depression) or personality disorder (e.g., borderline personality disorder); conduct or refer to an evidence-based intervention for the disorder (see, for example, interpersonal therapy for unipolar depression, interpersonal and social rhythm therapy for bipolar depression, or dialectical behavior therapy for borderline personality disorders in appropriate chapters in this *Planner*).
 14. Assess the client's need for psychotropic medication and arrange for a prescription, if necessary.
 15. Monitor the client for effectiveness, side effects, and compliance with prescribed psychotropic medication; confer with prescribing physician on a regular basis.
 16. Explore the client's sources of emotional pain and hopelessness.
 17. Encourage the client to express feelings related to his/her suicidal ideation in order to clarify them and increase insight as to the causes for them.

11. Increase communication with significant others, resulting in a feeling of understanding, empathy, and being attended to. (22, 23, 24)
12. Identify how previous attempts to solve interpersonal problems have failed, leading to feelings of abject loneliness and rejection. (25, 26)
13. Learn and implement problem-solving and decision-making skills. (27, 28)
21. Assist the client in becoming aware of life factors that were significant precursors to the beginning of his/her suicidal ideation.
22. Probe the client's feelings of despair related to his/her conflicted family relationships.
23. Hold family therapy sessions to promote communication of the client's feelings of sadness, hurt, and anger.
24. Meet with significant others to assess their understanding of the causes for the client's distress.
25. Encourage the client to share feelings of grief related to broken close relationships.
26. Review with the client previous problem-solving attempts and discuss new alternatives that are available.
27. Use a Problem-Solving Therapy approach (see *Problem-Solving Therapy* by D'Zurilla and Nezu under Unipolar Depression) involving psychoeducation, modeling, and role-playing to teach client personal problem-solving skills (i.e., defining a problem specifically, generating possible solutions, evaluating the pros and cons of each solution, selecting and implementing a plan of action, evaluating the efficacy of the plan, accepting or revising the plan); role-play application of the problem-solving skill to a real life issue (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult*

*Psychotherapy Homework
Planner* by Jongsma).

14. Reestablish a consistent eating and sleeping pattern. (29)
15. Commit to the use of coping strategies for suicidal urges. (30)
16. Identify the positive aspects, relationships, and achievements in his/her life. (31, 32)
17. Learn and implement behavioral strategies designed to increase engagement in rewarding activities. (33, 34)
28. Encourage in the client the development of a positive problem orientation in which problems and solving them are viewed as a natural part of life and not something to be despaired, approached passively, or avoided.
29. Encourage normal eating and sleeping patterns by the client and monitor his/her compliance.
30. Assist the client in developing coping strategies for suicidal ideation (e.g., more physical exercise, less internal focus, increased social involvement, more expression of feelings, and contact with therapist).
31. Ask the client to write a list of positive aspects of his/her life (or assign “What’s Good About Me and My Life” in the *Adult Psychotherapy Homework Planner* by Jongsma).
32. Review with the client the success he/she has had and the sources of love and concern that exist in his/her life.
33. Engage the client in “behavioral activation,” increasing his/her activity level and contact with sources of reward, while identifying processes that inhibit activation (see *Behavioral Activation for Depression* by Martell, Dimidjian, and Herman-Dunn under Unipolar Depression in Appendix B; or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework*

- Planner* by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, or role reversal, as needed, to facilitate activity in the client's daily life; reinforce success.
18. Identify and replace negative thinking patterns that mediate feelings of hopelessness and helplessness. (35, 36, 37, 38)
 34. Assist the client in developing skills that increase the likelihood of deriving pleasure from behavioral activation (e.g., assertiveness skills, developing an exercise plan, less internal/more external focus, increased social involvement); reinforce success.
 35. Assist the client in developing an awareness of the cognitive messages that reinforce hopelessness and helplessness.
 36. Assist the client in identifying, challenging, and changing biased cognition, allowing for a more realistic perspective conducive to hope (or assign "Journal of Distorted, Negative Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 37. Address underlying assumptions to self-talk that may be contributing to biases (e.g., beliefs about self-worthlessness, hopelessness).
 38. Ask the client to keep a daily record of self-defeating thoughts (thoughts of hopelessness, helplessness, worthlessness, catastrophizing, negatively predicting the future, etc.); challenge each thought for accuracy, then replace each dysfunctional thought with one that is positive and self-enhancing; review;

- reward successes; problem-solve obstacles toward positive cognitive change.
- 19. Verbalize the devastating effects that suicide can have on significant others. (39)
 - 20. Verbalize a feeling of support that results from spiritual faith. (40, 41)
 - 39. Assist the client in reviewing the effects that the client’s suicide would have on loved ones (or assign “The Aftermath of Suicide” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 - 40. Explore the client’s spiritual belief system as to it being a source of acceptance and peace (or assign “My History of Spirituality” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 - 41. Arrange for the client’s spiritual leader to meet with and support the client.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	300.4	Dysthymic Disorder
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	296.89	Bipolar II Disorder
	_____	_____
	_____	_____

Axis II:	301.83	Borderline Personality Disorder

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F31.xx	Bipolar I Disorder
300.4	F34.1	Persistent Depressive Disorder
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
296.89	F31.81	Bipolar II Disorder
301.83	F60.3	Borderline Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

TYPE A BEHAVIOR

BEHAVIORAL DEFINITIONS

1. A pattern of pressuring self and others to accomplish more because there is never enough time.
2. A spirit of intense competition in all activities.
3. Intense compulsion to win at all costs regardless of the activity or co-competitor.
4. Inclination to dominate all social or business situations, being too direct and overbearing.
5. Propensity to become irritated by the action of others who do not conform to own sense of propriety or correctness.
6. A state of perpetual impatience with any waiting, delays, or interruptions.
7. Difficulty in sitting and quietly relaxing or reflecting.
8. Psychomotor facial signs of intensity and pressure (e.g., muscle tension, scowling, glaring, or tics).
9. Psychomotor voice signs (e.g., irritatingly forceful speech or laughter, rapid and intense speech, and frequent use of obscenities).

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LONG-TERM GOALS

1. Formulate and implement a new life attitudinal pattern that allows for a more relaxed pattern of living.

2. Reach a balance between work/competitive and social/noncompetitive time in daily life.
3. Achieve an overall decrease in pressured, driven behaviors.
4. Develop social and recreational activities as a routine part of life.
5. Alleviate sense of time urgency, free-floating anxiety, anger, and self-destructive behaviors.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

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|---|--|
| <ol style="list-style-type: none">1. Describe the pattern of pressured, driven living. (1, 2)
2. Comply with psychological assessment. (3, 4)
3. Disclose any history of substance use that may contribute to and complicate the treatment of Type A behavior. (5)
4. Provide behavioral, emotional, and attitudinal information | <ol style="list-style-type: none">1. Assess examples of pressured lifestyle including associated situations, cognition, emotion, actions, and impact on client and others.2. Assist the client to see self as others do.3. Administer measure to assess and track the breadth and depth of Type A behavior (e.g., <i>Jenkins Activity Survey</i>).4. Review and process results of testing with the client toward increasing motivation for change.5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this <i>Planner</i>).6. Assess the client's level of insight (syntonic versus dystonic) |
|---|--|

toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)

toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
9. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment

- (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Identify the beliefs that support driven, overachieving behavior. (10, 11, 12)
 6. Verbalize a desire to reprioritize values toward less self-focus, more inner and other orientation. (13, 14)
 7. Verbalize a commitment to learning new approaches managing self, time, and relationships that emphasize the values of inner and other orientation. (15)
 10. Probe personal history including family of origin history for role models of and/or pressure for high achievement and compulsive drive.
 11. Ask the client to make a list of his/her beliefs about self-worth and the worth of others; process it with the therapist.
 12. Assist the client in making key connections between his/her overachieving/driven behavior and the desire to please key parental figures.
 13. Explore and clarify the client's value system and assist in developing new priorities on the importance of relationships, recreation, spiritual growth, reflection time, giving to others (or assign "Developing Noncompetitive Values" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 14. Ask the client to read biographies or autobiographies of spiritual people (e.g., St. Augustine, Thomas Merton, Albert Schweitzer, C. S. Lewis); process the key beliefs they lived by.
 15. Ask the client to commit to attempting attitude and behavior changes to promote a healthier, less Type A lifestyle; explore with him/her what changes need to be made to become less Type A. ▽

- ▼^{EB} 8. Develop the pattern of doing one task at a time with less emphasis on pressure to complete it quickly. (16)
- ▼^{EB} 9. Decrease the number of hours worked daily and the frequency of taking work home. (17)
- ▼^{EB} 10. Learn and implement calming skills as a lifestyle change and to manage pressure situations. (18, 19)
- ▼^{EB} 11. Increase daily time involved in relaxing activities. (20, 21, 22, 23)
16. Encourage and reinforce the client, focusing on one activity at a time without a sense of urgency; direct him/her to calmly complete the task before moving on to another task. ▼^{EB}
17. Review the client's pattern of hours spent working (at home and office) and recommend selected reductions; explore how these reductions could be accomplished (what specifically needs to change?). ▼^{EB}
18. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to feelings of pressure when they occur (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay). ▼^{EB}
19. Assign the client to implement calming techniques in his/her daily life in general and when facing trigger situations; process the results, reinforcing success and provide corrective feedback toward improvement. ▼^{EB}
20. Assign the client to do at least one noncompetitive activity each day for a week; process this experience. ▼^{EB}
21. Ask the client to try at least one area of interest outside of his/her vocation that he/she will do two times weekly for one month (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼^{EB}

- ▽^{EB} 12. Identify and replace distorted automatic thoughts that motivate pressured living. (24)
- ▽^{EB} 13. Verbalize a recognition of hostility toward and impatience with others. (25, 26)
- ▽^{EB} 14. Learn and implement respectful assertive communication knowledge and skills to replace insensitive directness or verbal aggression that is controlling. (27, 28)
22. Assign the client to watch comedy movies or other pleasant activities and identify the positive aspects and consequences of them. ▽^{EB}
23. Reinforce all the client changes that reflect a greater sense of life balance. ▽^{EB}
24. Assist the client in identifying distorted automatic thoughts that lead to feeling pressured to achieve; assist him/her in replacing these distortions with positive, realistic cognitions. ▽^{EB}
25. Explore the client's pattern of intolerant, impatient interaction with others. ▽^{EB}
26. Assist the client in identifying his/her critical beliefs about other people and connecting them to hostile verbal and behavior patterns in daily life; challenge him/her to develop alternative thoughts that mediate tolerance and acceptance of others. ▽^{EB}
27. Train the client in assertive communication with emphasis on recognizing and refraining from aggressive communication (e.g., ignoring of the rights of others) to respectful, assertive communication. ▽^{EB}
28. Monitor, point out, and reframe the client's actions or verbalizations that reflect a self-centered or critical approach to others; practice alternatives using behavioral strategies such as modeling, role-playing, and/or role reversal. ▽^{EB}

- ▽^{EB} 15. Learn problem-solving and/or conflict resolution skills to manage interpersonal problems. (29, 30)
- ▽^{EB} 16. Practice using new calming, cognitive, communication, and problem-solving skills in session with the therapist and during homework exercises. (31, 32, 33)
17. Demonstrate decreased impatience with others by talking of appreciating and
29. Teach the client conflict resolution skills (e.g., empathy, active listening, “I messages,” respectful communication, assertiveness without aggression, compromise); use role-play and modeling to apply these skills to current conflicts. ▽^{EB}
30. Teach the client problem-solving skills (e.g., define the problem specifically, brainstorm options, list the pros and cons of each option, chose and implement an option, evaluate the outcome); use modeling, role-playing, and behavior rehearsal to apply this skill to several current conflicts (or assign “Plan Before Acting” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽^{EB}
31. Assist the client in constructing a client-tailored strategy for managing pressure that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs. ▽^{EB}
32. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing stress. ▽^{EB}
33. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, in vivo exposure, or behavioral experiments to help the client consolidate the use of his/her new stress management skills. ▽^{EB}
34. Assign the client to talk to an associate or child, focusing on listening to the other person and

- understanding the good qualities in others. (34, 35, 36, 37)
- learning several good things about that person; process the experience.
35. Assign the client and family to attend an experiential weekend that promotes self-awareness (e.g., high/low ropes course or cooperative tasks); process the experience afterwards.
 36. Assign the client to go with a group on a wilderness camping and canoeing trip, on a work camp project, or with the Red Cross as a disaster worker; process the experience.
 37. Encourage the client to volunteer for a nonprofit social agency, school, or the like for one year, doing direct work with people (i.e., serving food at a soup kitchen or tutoring an inner-city child); process the positive consequences.
 38. Encourage and monitor the client in doing one random, spontaneous act of kindness on a daily basis and explore the positive results.
 39. Encourage the client to express warmth, appreciation, affection, and gratitude to others.
 40. Assign the client to read the book *The Road Less Traveled* by Peck and to process key ideas with therapist.
 41. Assign the client to read “List of Aphorisms” in *Treating Type A Behavior and Your Heart* by Friedman and Ulmer three times daily for one or two weeks; then to pick several to incorporate into his/her life.
18. Increase interest in the lives of others as evidenced by listening to others talk of their life experiences, and by engaging in one act of kindness per day. (38, 39, 40)
 19. Develop a daily routine that reflects a balance between the quest for achievement and appreciation of aesthetic things. (41, 42)

20. Participate in Acceptance and Commitment Therapy (ACT) to learn a new approach to life and its stresses. (43, 44, 45, 46)
42. Ask the client to list activities he/she could engage in for purely aesthetic enjoyment (e.g., visit an art museum, attend a symphony concert, hike in the woods, take painting lessons, etc.) and incorporate these into his/her life.
43. Use an ACT approach to help the client accept and openly experience anxious thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Learning ACT: An Acceptance and Commitment Therapy Skills-Training Manual for Therapists* by Luoma, Hayes, and Walser).
44. Teach mindfulness meditation to help the client recognize the negative thought processes associated with panic and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
45. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into in everyday life.
46. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Get Out of Your Mind and Into*

Your Life: The New Acceptance and Commitment Therapy by Hayes).

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DIAGNOSTIC SUGGESTIONS


Using DSM-IV/ICD-9-CM:

Axis I:	300.3	Obsessive-Compulsive Disorder
	300.02	Generalized Anxiety Disorder
	296.89	Bipolar II Disorder, Hypomanic
	_____	_____
	_____	_____
Axis II:	301.4	Obsessive-Compulsive Personality Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.3	F42	Obsessive-Compulsive Disorder
300.02	F41.1	Generalized Anxiety Disorder
296.89	F31.81	Bipolar II Disorder
301.4	F60.5	Obsessive-Compulsive Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

UNIPOLAR DEPRESSION

BEHAVIORAL DEFINITIONS

1. Depressed or irritable mood.
2. Decrease or loss of appetite.
3. Diminished interest in or enjoyment of activities.
4. Psychomotor agitation or retardation.
5. Sleeplessness or hypersomnia.
6. Lack of energy.
7. Poor concentration and indecisiveness.
8. Social withdrawal.
9. Suicidal thoughts and/or gestures.
10. Feelings of hopelessness, worthlessness, or inappropriate guilt.
11. Low self-esteem.
12. Unresolved grief issues.
13. Mood-related hallucinations or delusions.
14. History of chronic or recurrent depression for which the client has taken antidepressant medication, been hospitalized, had outpatient treatment, or had a course of electroconvulsive therapy.

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LONG-TERM GOALS

1. Alleviate depressive symptoms and return to previous level of effective functioning.

2. Recognize, accept, and cope with feelings of depression.
3. Develop healthy thinking patterns and beliefs about self, others, and the world that lead to the alleviation and help prevent the relapse of depression.
4. Develop healthy interpersonal relationships that lead to the alleviation and help prevent the relapse of depression.
5. Appropriately grieve the loss in order to normalize mood and to return to previously adaptive level of functioning.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

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| <ol style="list-style-type: none"> 1. Describe current and past experiences with depression including their impact on functioning and attempts to resolve it. (1, 2)
 2. Complete psychological testing to assess the depth of depression, the need for anti-depressant medication, and suicide prevention measures. (3) | <ol style="list-style-type: none"> 1. Encourage the client to share his/her thoughts and feelings of depression; express empathy and build rapport while identifying primary cognitive, behavioral, interpersonal, or other contributors to depression. 2. Assess current and past mood episodes including their features, frequency, severity, and duration (e.g., clinical interview supplemented by the <i>Inventory to Diagnose Depression</i>). 3. Arrange for the administration of an objective assessment instrument for evaluating the client's depression and suicide risk (e.g., <i>Beck Depression Inventory-II</i>; the <i>Beck Hopelessness Scale</i>); evaluate results and give feedback to the client; readminister as indicated to assess treatment progress. |
|---|--|

3. Verbalize any history of past and present suicidal thoughts and actions. (4)
4. State no longer having thoughts of self-harm. (5, 6)
5. Complete a medical evaluation to assess for possible contribution of medical or substance-related conditions to the depression. (7)
6. Disclose any history of substance use that may contribute to and complicate the treatment of unipolar depression. (8)
7. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (9, 10, 11, 12)
4. Assess the client's history of suicidality and current state of suicide risk (see the Suicidal Ideation chapter in this *Planner* if suicide risk is present).
5. Continuously assess and monitor the client's suicide risk.
6. Arrange for hospitalization, as necessary, when the client is judged to be a danger to self.
7. Refer the client to a physician for a medical evaluation to rule out general medical or substance-related causes of the depression.
8. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
9. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD,

depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

11. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
12. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
8. Cooperate with a medication evaluation by a physician. (13, 14)
13. Evaluate the client’s need and desire for psychotropic medication and, if indicated, arrange for a medication evaluation by a physician.
14. Monitor and evaluate the client’s psychotropic medication compliance, effectiveness, and side effects; communicate with prescribing physician.
9. Verbalize an accurate understanding of depression. (15, 16)
15. Consistent with the treatment model, discuss how cognitive, behavioral, interpersonal, and/or

- other factors (e.g., family history) contribute to depression. ▽
16. Assign the client to read chapters, books, treatment manuals, or other resources that convey psychoeducational concepts regarding depression. ▽
17. Consistent with the treatment model, discuss how change in cognitive, behavioral, interpersonal, and other factors can help the client alleviate depression and return to previous level of effective functioning. ▽
18. Assign the client to read chapters, books, or use other resources to help the client learn more about the therapy and its rationale. ▽
19. Conduct Cognitive-Behavioral Therapy (see *Cognitive Behavior Therapy* by Beck; *Overcoming Depression* by Gilson, et al.), beginning with helping the client learn the connection among cognition, depressive feelings, and actions. ▽
20. Assign the client to self-monitor thoughts, feelings, and actions in daily journal (e.g., “Negative Thoughts Trigger Negative Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma; “Daily Record of Dysfunctional Thoughts” in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts. ▽
- ▽ 10. Verbalize an understanding of the rationale for treatment of depression. (17, 18)
- ▽ 11. Identify and replace thoughts and beliefs that support depression. (19, 20, 21, 22, 23)

21. Assign “behavioral experiments” in which depressive automatic thoughts are treated as hypotheses/prediction, reality-based alternative hypotheses/prediction are generated, and both are tested against the client’s past, present, and/or future experiences. ▽
 22. Facilitate and reinforce the client’s shift from biased depressive self-talk and beliefs to reality-based cognitive messages that enhance self-confidence and increase adaptive actions (see “Positive Self-Talk” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
 23. Explore and restructure underlying assumptions and beliefs reflected in biased self-talk that may put the client at risk for relapse or recurrence. ▽
 24. Engage the client in “behavioral activation,” increasing his/her activity level and contact with sources of reward, while identifying processes that inhibit activation (see *Behavioral Activation for Depression* by Martell, Dimidjian, and Herman-Dunn; or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, role reversal, as needed, to facilitate activity in the client’s daily life; reinforce success. ▽
 25. Assist the client in developing skills that increase the likelihood of deriving pleasure from
- ▽ 12. Learn and implement behavioral strategies to overcome depression. (24, 25)

- behavioral activation (e.g., assertiveness skills, developing an exercise plan, less internal/more external focus, increased social involvement); reinforce success. ▽
- ▽ 13. Identify important people in life, past and present, and describe the quality, good and poor, of those relationships. (26)
- ▽ 14. Verbalize an understanding and resolution of current interpersonal problems. (27, 28, 29, 30)
26. Conduct Interpersonal Therapy (see *Interpersonal Psychotherapy of Depression* by Klerman et al.), beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships; develop a case formulation linking depression to grief, interpersonal role disputes, role transitions, and/or interpersonal deficits). ▽
27. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss. ▽
28. For interpersonal disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship. ▽
29. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role,

- and taking steps to gain mastery over the new role. ▾
30. For interpersonal deficits, help the client develop new interpersonal skills and relationships. ▾
- ▾ 15. Learn and implement problem-solving and decision-making skills. (31, 32)
31. Conduct Problem-Solving Therapy (see *Problem-Solving Therapy* by D’Zurilla and Nezu) using techniques such as psychoeducation, modeling, and role-playing to teach client problem-solving skills (i.e., defining a problem specifically, generating possible solutions, evaluating the pros and cons of each solution, selecting and implementing a plan of action, evaluating the efficacy of the plan, accepting or revising the plan); role-play application of the problem-solving skill to a real life issue (or assign “Applying Problem-Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▾
32. Encourage in the client the development of a positive problem orientation in which problems and solving them are viewed as a natural part of life and not something to be feared, despaired, or avoided. ▾
- ▾ 16. Learn and implement conflict resolution skills to resolve interpersonal problems. (33, 34)
33. Teach conflict resolution skills (e.g., empathy, active listening, “I messages,” respectful communication, assertiveness without aggression, compromise); use psychoeducation, modeling, role-playing, and rehearsal to work through several current conflicts; assign homework exercises; review and repeat so as

to integrate their use into the client's life. ▾

34. Help the client resolve depression related to interpersonal problems through the use of reassurance and support, clarification of cognitive and affective triggers that ignite conflicts, and active problem-solving (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▾
35. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a rather common, temporary setback that may involve, for example, reexperiencing a depressive thought and/or urge to withdraw or avoid (perhaps as related to some loss or conflict) and a relapse as a sustained return to a pattern of depressive thinking and feeling usually accompanied by interpersonal withdrawal and/or avoidance. ▾
36. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. ▾
37. Build the client's relapse prevention skills by helping him/her identify early warning signs of relapse and rehearsing the use of skills learned during therapy to manage them. ▾
38. Use mindfulness meditation and cognitive therapy techniques to help the client learn to recognize and regulate the negative thought processes associated
- ▾ 17. Learn and implement relapse prevention skills. (35, 36, 37)
- ▾ 18. Implement mindfulness techniques for relapse prevention. (38, 39)

with depression and to change his/her relationship with these thoughts (see *Mindfulness-Based Cognitive Therapy for Depression* by Segal, Williams, and Teasdale).[▽]

19. Participate in couples therapy to decrease depression and improve the relationship. (40)
20. Verbalize an understanding of healthy and unhealthy emotions with the intent of increasing the use of healthy emotions to guide actions. (41)
21. Verbalize insight into how past relationships may be influencing
39. Work to increase the client's new sense of well-being by building his/her personal strengths evident in their progress through therapy (or assign "Acknowledging My Strengths" and/or "What Are My Good Qualities?" in the *Adult Psychotherapy Homework Planner* by Jongsma).[▽]
40. Conduct Behavioral Couples Therapy using behavioral interventions focused on exchanges between partners including assertive communication, and problem-solving/ conflict resolution; focus on consistent use of respectful assertive communication, increasing caring exchanges between partners, and fostering collaborative problem-solving (see *Integrative Couples Therapy* by Jacobson and Christensen).
41. Use a process-experiential approach consistent with Emotion-Focused Therapy to create a safe, nurturing environment in which the client can process emotions, learning to identify and regulate unhealthy feelings and to generate more adaptive ones that then guide actions (see *Emotion-Focused Therapy for Depression* by Greenberg and Watson).
42. Conduct Brief Psychodynamic Therapy for depression to help

- current experiences with depression. (42, 43, 44, 45)
- the client increase insight into the role that past relational patterns may be influencing current vulnerabilities to depression; identify core conflictual themes; process with the client toward making changes in current relational patterns (see *Supportive-Expressive Dynamic Psychotherapy of Depression* by Luborsky et al.).
43. Explore experiences from the client's childhood that contribute to current depressed state.
 44. Encourage the client to share feelings of anger regarding pain inflicted on him/her in childhood that contributed to current depressed state.
 45. Explain a connection between previously unexpressed (repressed) feelings of anger (and helplessness) and current state of depression.
 22. Use mindfulness and acceptance strategies to reduce experiential and cognitive avoidance and increase value-based behavior. (46)
 46. Conduct Acceptance and Commitment Therapy (see *ACT for Depression* by Zettle) including mindfulness strategies to help the client decrease experiential avoidance, disconnect thoughts from actions, accept one's experience rather than change or control symptoms, and behave according to his/her broader life values; assist the client in clarifying his/her goals and values and commit to behaving accordingly (or assign "Developing Noncompetitive Values" in the *Adult Psychotherapy Homework Planner* by Jongsma).

23. Read books on overcoming depression. (47)

24. Increasingly verbalize hopeful and positive statements regarding self, others, and the future. (48, 49)

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47. Recommend that the client read self-help books consistent with the therapeutic approach used in therapy to help supplement therapy and foster better understanding of it (e.g., *A Cognitive Behavioral Workbook for Depression: A Step-by-Step Program* by Knaus; *Solving Life's Problems* by Nezu, Nezu, and D'Zurilla; *The Interpersonal Solution to Depression: A Workbook for Changing How You Feel by Changing How You Relate* by Pettit and Joiner; *The Mindfulness and Acceptance Workbook for Depression* by Strosahl and Robinson); process material read.

48. Assign the client to write at least one positive affirmation statement daily regarding himself/herself and the future (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

49. Teach the client more about depression and how to recognize and accept some sadness as a normal variation in feeling.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:


Axis I:	309.0	Adjustment Disorder With Depressed Mood
	300.4	Dysthymic Disorder
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	310.1	Personality Change Due to Axis III Disorder
	311	Depressive Disorder NOS
	V62.82	Bereavement

Axis II:	301.9	Personality Disorder NOS
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.0	F43.21	Adjustment Disorder, With Depressed Mood
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
300.4	F34.1	Persistent Depressive Disorder
301.13	F34.0	Cyclothymic Disorder
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
310.1	F07.0	Personality Change Due to Another Medical Condition
V62.82	Z63.4	Uncomplicated Bereavement

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and DSM-5 Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

VOCATIONAL STRESS

BEHAVIORAL DEFINITIONS

1. Feelings of anxiety and depression secondary to interpersonal conflict in the work setting.
2. Feelings of inadequacy, fear, and failure secondary to severe business losses.
3. Fear of failure secondary to success or promotion that increases perceived expectations for greater success.
4. Rebellion against and/or conflicts with authority figures in the employment situation.
5. Feelings of anxiety and depression secondary to being fired or laid off, resulting in unemployment.
6. Anxiety related to perceived or actual job jeopardy.
7. Feelings of depression and anxiety related to complaints of job dissatisfaction or the stress of employment responsibilities.

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LONG-TERM GOALS

1. Improve satisfaction and comfort surrounding coworker relationships.
2. Increase sense of confidence and competence in dealing with work responsibilities.
3. Be cooperative with and accepting of supervision of direction in the work setting.

4. Increase sense of self-esteem and elevation of mood in spite of unemployment.
5. Increase job security as a result of more positive evaluation of performance by a supervisor.
6. Pursue employment consistency with a reasonably hopeful and positive attitude.
7. Increase job satisfaction and performance due to implementation of assertiveness and stress management strategies.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

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| <ol style="list-style-type: none"> 1. Describe the nature and history of the vocational stress. (1, 2)
 2. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (3)
 3. Disclose any history of substance use that may contribute to and complicate the treatment of vocational stress. (4) | <ol style="list-style-type: none"> 1. Establish rapport with the client toward building a therapeutic alliance.
 2. Assess the client's history of vocational stress including perceived sources, client distress and disability, adaptive and maladaptive coping actions, and goals of treatment.
 3. Administer a measure assessing the client's stressors and/or appraisals of stress and/or general sources of stress (e.g., <i>The Derogatis Stress Profile; The Daily Hassles and Uplifts Scale</i>).
 4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this <i>Planner</i>). |
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4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with an evaluation by a physician for psychotropic medication. (9)
6. Take prescribed psychotropic medication on a consistent basis. (10)
- ▽ 7. Participate in Stress Inoculation Training to alleviate stress and achieve personal goals. (11, 12, 13, 14, 15)
9. Arrange for a medication evaluation by a psychiatrist to assess the potential usefulness of a medication intervention.
10. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.
11. Use a Stress Inoculation Training approach beginning with a functional assessment of the stress problem including the contribution of the work environment, the client, and their interaction (see *Stress Inoculation Training* by Meichenbaum). ▽
12. Assist the client in conceptualizing stress including the role of cognitive appraisals, personal and interpersonal skills, and skills deficits, tying the conceptualization into the rationale for treatment. ▽
13. Use cognitive-behavioral techniques (e.g., instruction, modeling, practice, rehearsal, graduated application, and generalization) to train tailored personal and interpersonal skills (e.g., calming/relaxation, cognitive, coping, social/communication, problem-solving,

etc.) to facilitate adaptation and management of stress. ▽

14. Assign the client exercises in which he/she applies newly learned skills in increasingly challenging stressful situations; review; reinforce successes; problem-solve obstacles toward effective use. ▽
 15. Do relapse prevention training using common considerations such as differentiating a lapse from relapse, identifying and rehearsing the management of high-risk situations; and continued, everyday application of skills learned in therapy. ▽
 16. Assign the client to write a plan for constructive action (e.g., polite compliance with directedness, initiate a smiling greeting, compliment others' work, avoid critical judgments) that contains various alternatives to coworker or supervisor conflict. ▽
 17. Use role-playing, behavioral rehearsal, and role rehearsal to increase the client's probability of positive encounters and to reduce anxiety with others in employment situation or job search (recommend *Working Anger: Preventing and Resolving Conflict on the Job* by Potter-Effron). ▽
 18. Train the client in assertiveness skills or refer to assertiveness training class that teaches effective communication of needs and feelings without aggression or defensiveness. ▽
- ▽ 8. Identify and implement behavioral changes that could be made in workplace interactions to help resolve conflicts with coworkers or supervisors. (16, 17)
 - ▽ 9. Implement assertiveness skills. (18)

- ▼^{EB} 10. Learn and implement problem-solving skills. (19)
- ▼^{EB} 11. Verbalize healthy, realistic cognitive messages that promote harmony with others, self-acceptance, and self-confidence. (20, 21)
- ▼^{EB} 12. Identify and replace distorted cognitive messages associated with feelings of job stress. (22, 23, 24)
19. Conduct Problem-Solving Therapy (see *Problem-Solving Therapy* by D’Zurilla and Nezu) using techniques such as psychoeducation, modeling, and role-playing to teach the client problem-solving skills (i.e., defining a problem specifically, generating possible solutions, evaluating the pros and cons of each solution, selecting and implementing a plan of action, evaluating the efficacy of the plan, accepting or revising the plan); role-play application of the problem-solving skill to a real life issue (or assign “Applying Problem-Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma).▼^{EB}
20. Teach the client the connection between thoughts, feelings, and behavior; train the client in the development of more realistic, healthy cognitive messages that relieve anxiety and depression.▼^{EB}
21. Require the client to keep a daily record of self-defeating thoughts (e.g., thoughts of hopelessness, worthlessness, rejection, catastrophizing, negatively predicting the future); challenge each thought for accuracy, then replace each dysfunctional thought with one that is positive and self-enhancing (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma).▼^{EB}
22. Probe and clarify the client’s emotions surrounding his/her vocational stress.▼^{EB}

- ▽^{EB} 13. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (25, 26, 27)
23. Assess the client's distorted cognitive messages and schema that foster his/her vocational stress; replace these messages with positive cognitions (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma).^{▽^{EB}}
24. Confront the client's pattern of catastrophizing situations leading to immobilizing anxiety; replace these messages with realistic thoughts.^{▽^{EB}}
25. Teach the client calming/relaxation skills (e.g., applied relaxation, progressive muscle relaxation, cue controlled relaxation, mindful breathing, biofeedback) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life (e.g., *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay).^{▽^{EB}}
26. Assign the client homework each session in which he/she practices relaxation exercises daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success while providing corrective feedback toward improvement.^{▽^{EB}}
27. Assign the client to read about progressive muscle relaxation and other calming strategies in

relevant books or treatment manuals (e.g., *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow; *The Daily Relaxer: Relax Your Body, Calm Your Mind, and Refresh Your Spirit* by McKay and Fanning).¹⁸

14. Identify own role in the conflict with coworkers or supervisor. (28, 29)
15. Identify any personal problems that may be causing conflict in the employment setting. (30)
16. Review family-of-origin history to determine roots for interpersonal conflict. (31)
17. Identify patterns of similar conflict with people outside the work environment. (32)
18. Replace projection of responsibility for the conflict with acceptance of responsibility for own role in conflict. (33, 34)
19. Identify the effect that vocational stress has on feelings toward self and relationships with significant others. (35, 36)
28. Clarify the nature of the client's conflicts in the work setting.
29. Help the client identify his/her own role in the conflict, attempting to represent the other party's point of view.
30. Explore the client's transfer of personal problems to the employment situation.
31. Probe the client's family-of-origin history for causes of current interpersonal conflict patterns that are being reenacted in the work setting.
32. Explore the client's patterns of interpersonal conflict that occur beyond the work setting but are repeated in the work setting.
33. Confront the client's projection of responsibility for his/her behavior and feelings onto others; emphasize his/her need to examine his/her own role in the conflict.
34. Reinforce the client's acceptance of responsibility for personal feelings and behavior as they contribute to the conflict in the work setting.
35. Explore the effect of the client's vocational stress on his/her intra- and interpersonal dynamics with friends and family.

20. Develop and verbalize a plan for constructive action to reduce vocational stress. (37)
21. Verbalize an understanding of circumstances that led up to being terminated from employment. (38)
22. Cease self-disparaging comments that are based on perceived failure at workplace. (39, 40, 41, 42)
36. Facilitate a family therapy session in which feelings of family members can be aired and clarified regarding the client's vocational situation.
37. Assist the client in developing a plan to react positively to his/her vocational situation (or assign "My Vocational Action Plan" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the proactive plan and assist in its implementation.
38. Explore the causes for the client's termination of employment that may have been beyond his/her control.
39. Probe childhood history for roots of feelings of inadequacy, fear of failure, or fear of success.
40. Assist the client in developing a list of realistic, positive statements about himself/herself (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma); reinforce the client's realistic self-appraisal of successes and failures at workplace (recommend *The Self-Esteem Companion: Simple Exercises to Help You Challenge Your Inner Critic & Celebrate Your Personal Strengths* by McKay et al.).
41. Assign the client to separately list his/her positive traits, talents, and successful accomplishments, and then the people who care for, respect, and value him/her (or assign "What Are My Good Qualities?" in the *Adult Psychotherapy Homework Planner* by Jongsma); process

these lists as a basis for genuine gratitude and self-worth.

- 23. Outline plan for job search. (43, 44, 45)
- 42. Teach the client that the ultimate worth of an individual is not measured in material or vocational success but in service to a higher power and others.
- 43. Help the client develop a written job plan that contains specific attainable objectives for job search (recommend *What Color Is Your Parachute?: A Practical Manual for Job-Hunters and Career-Changers* by Bolles).
- 44. Assign the client to choose jobs for follow up in the want ads and to ask friends and family about job opportunities (recommend *Fearless Job Hunting: Powerful Psychological Strategies for Getting the Job You Want* by Knaus et al.).
- 45. Assign the client to attend a job search class or resumé-writing seminar.
- 24. Report on job search experiences and feelings surrounding these experiences. (46)
- 46. Monitor, encourage, and process the client’s search for employment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	309.0	Adjustment Disorder With Depressed Mood
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	V62.2	Occupational Problem
	309.24	Adjustment Disorder With Anxiety
	303.90	Alcohol Dependence
	304.20	Cocaine Dependence
	304.80	Polysubstance Dependence

Axis II:	301.0	Paranoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.7	Antisocial Personality Disorder
	301.9	Personality Disorder NOS

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.0	F43.21	Adjustment Disorder, With Depressed Mood
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
V62.2	Z56.9	Other Problem Related to Employment
309.24	F43.22	Adjustment Disorder, With Anxiety
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
301.0	F60.0	Paranoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

Appendix A

BIBLIOTHERAPY SUGGESTIONS

General

Many references are made throughout the chapters to a therapeutic homework resource that was developed by the authors as a corollary to this *Complete Adult Psychotherapy Treatment Planner*, Fifth Edition (Jongsma, Peterson, and Bruce). This frequently cited homework resource book is:

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For more resources related to motivational interviewing, see the Motivational Interviewing online at <http://www.motivationalinterview.org/>

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Appendix B

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Appendix C

RECOVERY MODEL OBJECTIVES AND INTERVENTIONS

The Objectives and Interventions below are created around the 10 core principles developed by a multidisciplinary panel at the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004):

1. **Self-direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.
2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual

gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. **Hope:** Recovery provides the essential and motivating message of a better future—that people can overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.¹

The numbers used for Objectives in the treatment plan below correspond to the numbers above for the core principles. Each of the 10 Objectives was written to capture the essential theme of the like-numbered core principle. The numbers in parentheses after the Objectives denote the Interventions designed to assist the client in attaining each respective Objective. The clinician may select any or all of the Objectives and Intervention statements to include in the client’s treatment plan.

One generic Long-Term Goal statement is offered should the clinician desire to emphasize a recovery model orientation in the client’s treatment plan.

LONG-TERM GOALS

1. To live a meaningful life in a self-selected community while striving to achieve full potential during the journey of healing and transformation.

SHORT-TERM OBJECTIVES

1. Make it clear to therapist, family, and friends what path to recovery is preferred. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Explore the client’s thoughts, needs, and preferences regarding his/her desired pathway to recovery from (depression, bipolar disorder, PTSD, etc.).
2. Discuss with the client the alternative treatment

¹ From: Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Mental Health Information Center: Center for Mental Health Services (2004). *National consensus statement on mental health recovery*. Washington, DC: Author. Available: <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

- interventions and community support resources that might facilitate his/her recovery.
2. Specify any unique needs and cultural preferences that must be taken under consideration during the treatment process. (5, 6)
 3. Verbalize an understanding that decision making throughout the treatment process is self-controlled. (7, 8)
 4. Express mental, physical, spiritual and community needs and desires that should be integrated into the treatment process. (9, 10)
 3. Solicit from the client his/her preferences regarding the direction treatment will take; allow for these preferences to be communicated to family and significant others.
 4. Discuss and process with the client the possible outcomes that may result from his/her decisions.
 5. Explore with the client any cultural considerations, experiences, or other needs that must be considered in formulating a mutually agreed-upon treatment plan.
 6. Modify treatment planning to accommodate the client's cultural and experiential background and preferences.
 7. Clarify with the client that he/she has the right to choose and select among options and participate in all decisions that affect him/her during treatment.
 8. Continuously offer and explain options to the client as treatment progresses in support of his/her sense of empowerment, encouraging and reinforcing the client's participation in treatment decision making.
 9. Assess the client's personal, interpersonal, medical, spiritual, and community strengths and weaknesses.
 10. Maintain a holistic approach to treatment planning by integrating the client's unique

- mental, physical, spiritual, and community needs and assets into the plan; arrive at an agreement with the client as to how these integrations will be made.
5. Verbalize an understanding that during the treatment process there will be successes and failures, progress, and setbacks. (11, 12)
 6. Cooperate with an assessment of personal strengths and assets brought to the treatment process. (13, 14, 15)
 7. Verbalize an understanding of the benefits of peer support during the recovery process. (16, 17, 18)
 11. Facilitate realistic expectations and hope in the client that positive change is possible, but does not occur in a linear process of straight-line successes; emphasize a recovery process involving growth, learning from advances as well as setbacks, and staying this course toward recovery.
 12. Convey to the client that you will stay the course with him/her through the difficult times of lapses and setbacks.
 13. Administer to the client the *Behavioral and Emotional Rating Scale (BERS): A Strength-Based Approach to Assessment* by Epstein.
 14. Identify the client's strengths through a thorough assessment involving social, cognitive, relational, and spiritual aspects of the client's life; assist the client in identifying what coping skills have worked well in the past to overcome problems and what talents and abilities characterize his/her daily life.
 15. Provide feedback to the client of his/her identified strengths and how these strengths can be integrated into short-term and long-term recovery planning.
 16. Discuss with the client the benefits of peer support (e.g., sharing common problems, receiving advice regarding

- successful coping skills, getting encouragement, learning of helpful community resources, etc.) toward the client's agreement to engage in peer activity.
17. Refer the client to peer support groups of his/her choice in the community and process his/her experience with follow-through.
 18. Build and reinforce the client's sense of belonging, supportive relationship building, social value, and community integration by processing the gains and problem-solving the obstacles encountered through the client's social activities.
 19. Discuss with the client the crucial role that respect plays in recovery, reviewing subtle and obvious ways in which disrespect may be shown to or experienced by the client.
 20. Review ways in which the client has felt disrespected in the past, identifying sources of that disrespect.
 21. Encourage and reinforce the client's self-concept as a person deserving of respect; advocate for the client to increase incidents of respectful treatment within the community and/or family system.
 22. Develop, encourage, support, and reinforce the client's role as the person in control of his/her treatment and responsible for its application to his/her daily life; adopt a supportive role as a resource person to assist in the recovery process.
8. Agree to reveal when any occasion arises that respect is not felt from the treatment staff, family, self, or the community. (19, 20, 21)
 9. Verbalize acceptance of responsibility for self-care and participation in decisions during the treatment process. (22)

10. Express hope that better functioning in the future can be attained. (23, 24)
23. Discuss with the client potential role models who have achieved a more satisfying life by using their personal strengths, skills, and social support to live, work, learn, and fully participate in society toward building hope and incentive motivation.
24. Discuss and enhance internalization of the client's self-concept as a person capable of overcoming obstacles and achieving satisfaction in living; continuously build and reinforce this self-concept using past and present examples supporting it.

Appendix D

ALPHABETICAL INDEX OF SOURCES FOR ASSESSMENT INSTRUMENTS AND CLINICAL INTERVIEW FORMS CITED IN INTERVENTIONS

Title

Authors

Publisher, Source or Citation

Addiction Severity Index (ASI)

McLellan, Luborsky, O'Brien, and Woody

McLellan, A. T., Luborsky, L., O'Brien, C. P. & Woody, G. E. (1980). An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous & Mental Diseases*, 168, 26–33. Available from http://ada1.washington.edu/instruments/pdf/Addiction_Severity_Index_Baseline_Followup_4.pdf

Adolescent Psychopathology Scale–Short Form (APS–SF)

Reynolds

PAR

Alcohol Use Disorders Identification Test (AUDIT)

Babor, Higgins-Biddle, Saunders, and Monteiro

Babor, T. F., Biddle-Higgins, J. C., Saunders, J. B. & Monteiro, M. G. (2001). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care*. Geneva, Switzerland: World Health Organization. Available from http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

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Anger, Irritability, and Assault Questionnaire (AIAQ)

Coccaro, Harvey, Kupsaw-Lawrence, Herbert, and Bernstein
Coccaro, E. F., Harvey, P. D., Kupsaw-Lawrence, E., Herbert, J. L., & Bernstein, D. P. (1991). Development of neuropharmacologically based behavioral assessments of impulsive aggressive behavior. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 3(2), 44–51.

Anxiety Disorders Interview Schedule—Adult Version (ADIS)

Brown, DiNardo, and Barlow
Oxford University Press

Anxiety Sensitivity Index (ASI)

Reiss, Peterson, Gursky, and McNally
IDS Publishing

Beck Anxiety Inventory (BDI)

Beck
Pearson

Beck Depression Inventory—II (BDI—II)

Beck, Steer, and Brown
Pearson

Beck Hopelessness Scale (BHS)

Beck
Pearson

Body Dysmorphic Disorder Examination (BDDE)

Rosen and Reiter
Rosen, J. C., & Reiter, J. (1996). Development of the body dysmorphic disorder examination. *Behaviour Research and Therapy*, 34, 755–766.

Brief Symptom Inventory—18 (BSI—18)

Derogatis
Pearson

Buss-Durkee Hostility Inventory (BDHI)

Buss and Durkee
Buss, A. H., & Durkee, A. (1957). An inventory for assessing different kinds of hostility. *Journal of Counseling Psychology*, 21, 343–349.

CAGE

Ewing

Ewing, J. A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American medical Association*, 252, 1905–1907. Available from http://www.integration.samhsa.gov/clinical-practice/sbirt/CAGE_questionnaire.pdf

Clinical Monitoring Form (CMF)

Sachs, Guille, and McMurrich

Sachs, G. S., Guille, C., & McMurrich, S. L. (2002). A clinical monitoring form for mood disorders. *Bipolar Disorders*, 4(5), 323–327.

Daily Hassles and Uplifts Scale (HSUP)

Lazarus and Folkman

Available from <http://www.mindgarden.com/products/hsups.htm>

Dementia Rating Scale–2 (DRS-2)

Juriea, Leitter, and Mattis

PAR

Derogatis Stress Profile (DSP)

Derogatis

Available from http://www.derogatis-tests.com/dsp_synopsis.asp

Detailed Assessment of Posttraumatic Stress (DAPS)

Briere

PAR

Dissociative Experiences Scale (DES)

Bernstein and Putnam

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disorders*, 174(12), 727–735. Available from http://www.sidran.org/store/index.cfm?fuseaction=product.display&Product_ID=62

Dyadic Adjustment Scale (DAS)

Spainer

MHS

Eating Disorders Inventory–3 (EDI–3)

Garner

PAR

Eating Inventory (EI)

Stunkard and Messick

Pearson

Fear Survey Schedule–III (FSS–III)

Wolpe and Lang
EDITS

Geriatric Depression Scale (GDS)

Sheikh and Yesavage

Yesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., Adey, M., & Leirer, V. O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research*, 17, 37–49.

Sheikh, J. I., & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist*, 5, 165–173. Available from <http://www.stanford.edu/~yesavage/GDS.html>

Illness Attitude Scale (IAS)

Kellner

Kellner, R. (1986). Somatization and hypochondriasis. New York: Praeger.

Kellner, R. (1987). Abridged manual of the Illness Attitudes Scale. Department of Psychiatry, School of Medicine, University of New Mexico. Available from http://www.karger.com/ProdukteDB/katalogteile/isbn3_8055/_98/_53/suppmat/p166-IAS.pdf

Impact of Events Scale–Revised (IES–R)

Weiss and Marmar

Weiss, D. S., & Marmar, C. R. (1996). The Impact of Event Scale–Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York, NY: Guilford.

Available in above chapter and from <http://www.ptsd.va.gov/professional/pages/assessments/ies-r.asp>

Inventory to Diagnose Depression/Diagnostic Inventory for Depression (IDD/DID)

Zimmerman and Coryell; Zimmerman, Sheeran, and Young

Zimmerman, M., & Coryell, W. (1987). The inventory to diagnose depression: A self-report scale to diagnose major depressive disorder. *Journal of Consulting and Clinical Psychology*, 55(1), 55–59.

Zimmerman, M., Sheeran, T., & Young, D. (2004). The Diagnostic Inventory for Depression: A self-report scale to diagnose DSM-IV major depressive disorder. *Journal of Clinical Psychology*, 60(1), 87–110. Available from <http://online.library.wiley.com/doi/10.1002/jclp.10207/pdf>

Jenkins Activity Survey (JAS)

Jenkins, Zyzanski, and Rosenman
The Psychological Corporation

Liebowitz Social Anxiety Scale (LSAS)

Liebowitz

Available from <http://asp.cumc.columbia.edu/SAD/>

Marital Satisfaction Inventory-Revised (MSI-R)

Synder
MHS

Memory Impairment Screen (MIS)

Buschke, et al.
Buschke, H., Kuslansky, G., Katz, M., Stewart, W. F., Sliwinski, M. J., Eckholdt, H. M., & Lipton, R. B. (1999). Screening for dementia with the memory impairment screen. *Neurology*, 52(2), 231–238. Available from http://www.alz.org/documents_custom/mis.pdf

Michigan Alcohol Screening Test (MAST)

Selzer
Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry*, 127(12), 1653–1658. Available from http://www.projectcork.org/clinical_tools/html/MAST.html

Millon Adolescent Clinical Inventory (MACI)

Millon, Millon, David, and Grossman
Pearson

Mini Mental State Examination (MMSE)

Folstein and Folstein
PAR

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

Butcher et al.; Tellegen et al.; Ben-Porath et al.
Pearson

Mobility Inventory for Agoraphobia (MIA)

Chambless, Caputo, Jasin, Gracely, and Williams
Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E., & Williams, C. (1985). The Mobility Inventory for Agoraphobia. *Behaviour Research and Therapy*, 23, 35–44. Available from <http://www.psych.upenn.edu/~dchamb/questionnaires/index.html>

Montgomery-Asberg Depression Rating Scale (MADRS)

Montgomery and Asberg
Montgomery, S. A., & Asberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry*, 134, 382–389. Available from <http://www.psy-world.com/madrs.htm>

NEO Personality Inventory-Revised (NEO PI-R)

Costa and McCrae
PAR

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Obsessive-Compulsive Inventory-Revised (OCI-R)

Foa, et al.

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., & Salkovskis, P. M. (2002). The obsessive-compulsive inventory: Development and validation of a short version. *Psychological Assessment, 14*(4), 485–496.

OQ-45.2

Lambert and Burlingame

OQ Measures

Parenting Stress Index (PSI)

Abidin

PAR

Parent–Child Relationship Inventory (PCRI)

Gerard

Western Psychological Services

Penn State Worry Questionnaire (PSWQ)

Meyer, Miller, Metzger, and Borkovec

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28*, 487–495. Available from <https://outcometracker.org/library/PSWQ.pdf>

Perceived Criticism Measure (PCM)

Hooley and Teasdale

Hooley, J. M., & Teasdale, J. D. (1989). Predictors of relapse in unipolar depressives: Expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology, 98*, 229–235.

Pleasant Activities List (PAL)

Roozen, et al.

Roozen, H. G., Wiersema, H., Strietman, M., Feij, J. A., Lewinsohn, P. M., Meyers, R. J., Koks, M., & Vingerhoets, J. J. M. (2008). Development and psychometric evaluation of the Pleasant Activities List. *American Journal on Addictions, 17*, 422–435.

Posttraumatic Stress Diagnostic Scale

Foa

Pearson

PTSD Symptom Scale (PSS)

Foa, Riggs, Dansu, and Rothbaum

Foa, E., Riggs, D., Dancu, C., & Rothbaum, B. (1993). *Reliability and validity of a brief instrument for assessing post-traumatic stress disorder*. *Journal of Traumatic Stress*, 6, 459–474.

Available from <http://www.ptsd.va.gov/professional/pages/assessments/pss-i.asp>

Reasons for Living Scale (RFL)

Linehan, Goodstein, Nielson, and Chiles

Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology*, 51, 276–286. Available from <http://blogs.uw.edu/btrc/publications-assessment-instruments/>

Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)

Randolph

www.rbans.com

Schedule for Nonadaptive and Adaptive Personality-2 (SNAP-2)

Clark

Available from <http://www.upress.umn.edu/test-division/snap-2>, and <http://www.upress.umn.edu/test-division/to-order/to%20order>

Social Interaction Anxiety Scale (SIAS)

Mattick and Clarke

Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia, scrutiny fear, and social interaction anxiety. *Behaviour Research and Therapy*, 36, 455–470.

Social Phobia Inventory (SPI)

Connor, Davidson, Churchill, Sherwood, Foa, and Weisler

Connor, K. M., Davidson, J. R., Churchill, L. E., Sherwood, A., Foa, E., & Weisler, R. H. (2000). Psychometric properties of the Social Phobia Inventory (SPIN). New self-rating scale. *British Journal of Psychiatry*, 176, 379–386.

State-Trait Anger Expression Inventory (STAXI)

Spielberger

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State-Trait Anxiety Inventory (STAI)

Spielberger

PAR

Stirling Eating Disorder Scales (SEDS)

Williams and Power
Pearson

Suicidal Thinking and Behaviors Questionnaire (STBQ)

Chiles and Strosahl
Chiles, J. A., & Strosahl, K. D. (2005). *Clinical manual for assessment and treatment of suicidal patients*. Washington, DC: American Psychiatric Publishing.

Symptom Checklist-90-R (SCL-90-R)

Derogatis
Pearson

Whiteley Index (WI)

Pilowsky
Pilowsky, I. (1967). Dimensions of hypochondriasis. *British Journal of Psychiatry*, 113, 89–93.

Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)

Goodman, et al.
Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, 46, 1006–1011.

Young Mania Rating Scale (YMRS)

Young, Biggs, Ziegler, and Meyer
Young, R. C., Biggs, J. T., Ziegler, V. E., & Meyer, D. A. (1978). A rating scale for mania: Reliability, validity, and sensitivity. *British Journal of Psychiatry*, 133, 429–435.

Additional Sources of Commonly Used Scales and Measures

American Psychiatric Association. Online Assessment Measures. Available from www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Baer, L., & Blais, M. A. (2010). *Handbook of clinical rating scales and assessment in psychiatry and mental health*. New York, NY: Humana Press.
Outcome Tracker. Available from Outcometracker.org.
Rush, A. J., First, M. B., & Blacker, D. (2008). *Handbook of psychiatric measures* (2nd ed.). Washington, DC: American Psychiatric Publishing.