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ROBERT R. PERKINSON, ARTHUR E. JONGSMA, JR., AND TIMOTHY J. BRUCE

WILEY

The Addiction Treatment
Planner
Sixth Edition

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PracticePlanners®

Arthur E. Jongsma, Jr., Series Editor

The Addiction
Treatment Planner
Sixth Edition

Robert R. Perkinson

Arthur E. Jongsma, Jr

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WILEY

This edition first published 2022
© 2022 John Wiley & Sons, Inc.

Edition History

John Wiley & Sons, Inc. (1e, 1997); John Wiley & Sons, Inc. (2e, 2001); John Wiley & Sons, Inc. (3e, 2005);
John Wiley & Sons, Inc. (4e, 2008); John Wiley & Sons, Inc. (5e, 2014)

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Registered Office

John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, USA

Editorial Office

111 River Street, Hoboken, NJ 07030, USA

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Wiley also publishes its books in a variety of electronic formats and by print-on-demand. Some content that appears in standard print versions of this book may not be available in other formats.

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Library of Congress Cataloging-in-Publication Data

Names: Perkinson, Robert R., author. | Jongsma, Arthur E., Jr., 1943-
author. | Bruce, Timothy J., author.

Title: The addiction treatment planner / Robert R. Perkinson, Arthur E.
Jongsma, Timothy J. Bruce.

Description: Sixth edition. | Hoboken, NJ : Wiley, [2022] | Series: Wiley
PracticePlanners series | Includes index.

Identifiers: LCCN 2020034637 (print) | LCCN 2020034638 (ebook) | ISBN
9781119707851 (paperback) | ISBN 9781119707929 (adobe pdf) | ISBN
9781119707936 (epub)

Subjects: LCSH: Substance abuse—Treatment—Handbooks, manuals, etc. |
Substance abuse—Treatment—Planning—Handbooks, manuals, etc.

Classification: LCC RC564.15 .P47 2022 (print) | LCC RC564.15 (ebook) |
DDC 362.29—dc23

LC record available at <https://lcn.loc.gov/2020034637>

LC ebook record available at <https://lcn.loc.gov/2020034638>

Cover Design: Wiley

Set in 11/13 TimesNewRomanMTSTD by Straive, Chennai, India

To those who courageously overcome life-destroying addiction and to those
who counsel them along the path to recovery.

—A.E.J.

To the angels of mental health.

—R.R.P.

To all those who struggle with addiction, and those who dedicate their lives in
service to them.

—T.J.B.

ABOUT THE COMPANION WEBSITE

This book is accompanied by a companion website.

www.wiley.com/go/jongsma/addictiontp6e



This website includes:

- Appendix G: References to Empirical Support for Evidence-Based Chapters in the Complete Addiction Treatment Planner, 6th Edition

Please note that corresponding homework assignments can be digitally downloaded through purchase of *The Addiction Homework Planner, 6th Edition*.

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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 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*, *Adolescent Psychotherapy Treatment Planner*, and *Addictions Treatment Planner* all now in their sixth editions, but also Treatment Planners targeted to specialty areas of practice, including:
 - Co-occurring disorders
 - Integrated 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
 - Intellectual and developmental disability
 - Neuro rehabilitation
 - Older adults
 - Parenting skills
 - Pastoral counseling
 - Personality disorders
 - Probation and parole
 - Psychopharmacology

- 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, chemical dependence, anger management, 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:

- ***Evidence-Based Psychotherapy Treatment Planning Video Series*** offers 12 sixty-minute programs that provide step-by-step guidance on how to use empirically supported treatments to inform the entire treatment planning process. In a viewer-friendly manner, Drs. Art Jongsma and Tim Bruce discuss the steps involved in integrating evidence-based (EBT) Objectives and Interventions into a treatment plan. The research support for the EBTs is summarized and selected aspects of the EBTs are demonstrated in role-played counseling scenarios.

A companion Treatment Planning software product is also available:

- ***TheraScribe®***, the #1 selling treatment planning and clinical record-keeping software system for mental health professionals. TheraScribe® allows the user to import the data from any of the *Treatment Planner*,

Progress Notes Planner, or Homework Planner books into the software's expandable database to simply point and click to create a detailed, organized, individualized, and customized treatment plan along with optional integrated progress notes and homework assignments. TheraScribe® is available by calling 616-776-1745.

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

INTRODUCTION

ABOUT PRACTICEPLANNERS® TREATMENT PLANNERS

Pressure from third-party payers, 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 payers 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 or psychiatric diagnosis.

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 THE ADDICTION TREATMENT PLANNER

The *Addiction Treatment Planner* has been written for individual, group, and family counselors and psychotherapists who are working with adults and adolescents who are struggling with addictions to mood-altering chemicals, gambling, abusive eating, nicotine, or sexual promiscuity. The problem list of chapter titles reflects those addictive behaviors and the emotional, behavioral, interpersonal, social, personality, legal, medical, and vocational issues associated with those addictions. Whereas the focus of the original *Chemical Dependence Treatment Planner* was limited exclusively to substance abuse and its associated problems, the focus of later editions has been expanded to include other common addictive behaviors as well as other behavioral problems and psychiatric conditions in which addictive behavior may occur.

This sixth edition of *The Addiction Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based objectives and interventions
- Addition at the outset of every chapter of an evidence-based Objective and two Therapeutic Interventions highlighting the importance of establishing a positive relationship with the client
- Revised, expanded, and updated References to Empirical Support for Evidence-based Chapters (Appendix G) are now listed online at www.wiley.com/go/jongsma/addictiontp6e
- Revised, expanded, and updated self-help book list in the Bibliotherapy Suggestions (Appendix A)
- More suggested homework assignments from *Homework Planners* integrated into the interventions
- Updated Appendix F, which provides an Alphabetical Index of Sources for the Assessment Instruments and Clinical Interview Forms Cited in Interventions
- New chapters on Opioid Use and Panic Disorder/Agoraphobia
- Renamed chapters for Depression – Unipolar (formerly Unipolar Depression) and Readiness for Change (formerly Treatment Resistance)
- Exclusive use of *DSM-5 (ICD-10-CM)* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter

This edition of the *Planner* continues to give special attention to the Patient Placement Criteria (PPC) developed by the American Society of Addiction Medicine (ASAM). In the ASAM contents we have listed our presenting problem chapters under each of the six assessment dimensions:

- Dimension 1: Acute intoxication and/or withdrawal potential
- Dimension 2: Biomedical conditions and complications
- Dimension 3: Emotional, behavioral, or cognitive conditions and complications
- Dimension 4: Readiness to change
- Dimension 5: Relapse, continued use, or continued problem potential
- Dimension 6: Recovery/living environment

The *Addiction Treatment Planner* has treatment planning content applicable to problems discovered in all of the six assessment dimensions.

Also included (Appendix D) is a form that can be used to assess the client under the six ASAM dimensions. The checklist provides material for efficient evaluation of the client on each of the six dimensions. This form has been developed and is utilized by the staff at Keystone Treatment Center, Canton, South Dakota, where Dr. Perkinson is the clinical director. It is not copyrighted and may be used or adapted for use by our readers.

Interventions can be found in each chapter that reflect a 12-step recovery program approach, but you will also find interventions based on a broader

psychological and pharmacological model. Because addiction treatment is often done in a residential setting through a team approach, interventions have been created that can be assigned to staff members of various disciplines and modalities: nursing, medical, group counseling, family therapy, or individual therapy. We hope that we have provided a broad, eclectic menu of objectives and interventions from which you can select to meet your client's unique needs. Ideally, we have also provided a stimulus for you to create new objectives and interventions from your own clinical experience that have proven to be helpful to addictive clients.

Evidence-based practice (EBP) is steadily becoming the standard of care in mental health care as it has in medical health care. Professional organizations such as the American Psychological Association (APA), National Association of Social Workers, and the American Psychiatric Association, as well as consumer organizations such as the National Alliance for the Mentally Ill (NAMI) have all endorsed the use of EBP. In some practice settings, EBP is becoming mandated. Some third-party payers are requiring use of EBP for reimbursement. 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 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 EBP, 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 may have demonstrated efficacy, factors such as the individual psychologist (e.g. Wampold, 2001), the treatment relationship (e.g. Norcross, 2019), and the patient (e.g. Bohart & Tallman, 1999) are also vital contributors to optimizing a client's response to 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 12 DVD-based training videos entitled *Evidence-based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

The sources we used to identify the evidence-based treatments integrated into this *Planner* are multiple and, we believe, high quality. They include rigorous meta-analyses, current critical, expert reviews, as well as EBP guideline recommendations. Examples of specific sources include the Cochrane Collaboration reviews; the work of the Society of Clinical Psychology identifying research-supported psychological treatments; evidence-based treatment reviews (e.g. David, Lynn, & Montgomery, 2018; Nathan & Gorman, 2015), as well as critical analyses of the process through which EBP is defined

(e.g. Dimidjian, 2019; Norcross, Hogan, Koocher, & Maggio, 2017). EBP guidelines informing the selection process include those from the APA, American Psychiatric Association, the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom, and the National Institute on Drug Abuse (NIDA) to name a few.

Although sources may vary slightly in the criteria they use for judging levels of empirical support, we favored those that use more rigorous criteria, typically requiring demonstration of efficacy through randomized controlled trials or clinical replication series, good experimental methodology, 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 across most of these sources. For any chapter in which EBP is indicated, references to the sources used to identify them can be found online at www.wiley.com/go/jongsma/addictiontp6e. In addition to these references to empirical support, we have also included a Professional Reference appendix listing references to Clinical Resources. Clinical Resources are books, manuals, and other resources for clinicians that describe the details of the application, or the “how to,” of the treatment approaches described in a chapter.

We recognize that there is debate regarding EBP among mental health professionals, who are not always in agreement regarding the best treatment, what factors contribute to good outcomes, or even what constitutes “evidence.” We also recognize that some practitioners are skeptical about changing their practice based on psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of treatment plan options, including those consistent with the “best available research” (APA, 2006), those reflecting common clinical practices of experienced clinicians (that may have not been subjected to study), and some that reflect promising emerging approaches. Our intent is to allow users of this planner an array of options so that they can construct what they believe to be the best plan for their particular client.

More recently, psychotherapy research is moving toward trying to identify evidence-based principles of psychotherapeutic change that cut across the various individual psychotherapies that have largely been the focus of outcome research. An example of this call is seen in Goldfried (2019), in which he advances the following principles:

- Promoting client expectation and motivation that therapy can help,
- Establishing an optimal therapeutic alliance,
- Facilitating client awareness of the factors associated with his or her difficulties,
- Encouraging the client to engage in corrective experiences, and
- Emphasizing ongoing reality testing in the client’s life.

Although many endorse this effort, at the time of this writing it is still in progress. Consequently, our approach to identifying objectives and interventions consistent with EBPs reflects what has been done from the “principles” approach as well as the research demonstrating the efficacy and effectiveness

of individual models. Perhaps the field will advance enough by the next edition of this planner to include only evidence-based principles of psychotherapeutic change. Until then, we believe that the approach we have taken reflects the current state of the science.

We would also like to note that for those selecting EBT objectives and interventions in their treatment, fidelity to the EBT as it was delivered in the studies demonstrating its efficacy or effectiveness offers the best chance for reproducing its results for your client. A demonstration of this point was witnessed in a recently published meta-analysis examining 12-Step Facilitation Therapy (TSF; Kelly, Humphreys, & Kelly, 2020). The review found that TSF manualized interventions intended to increase Alcoholics Anonymous (AA) participation during and following alcohol use disorder (AUD) treatment lead to enhanced abstinence outcomes compared to other well-established treatments over the next few months and for up to three years. Of note was that fidelity to the TSF treatment model was critical to this outcome as conveyed in this statement by the authors:

...when different types of TSF interventions were tested against each other, the more intensive TSF interventions (e.g. those that include actively prescribing AA participation and ongoing monitoring of AA attendance and related experiences; personal linkages to existing AA members) often worked better at improving drinking-related outcomes than the “treatment as usual (TAU) TSF” intervention. This suggests that although many treatment professionals may believe that they “already do 12-step” (i.e. implement TSF strategies) because they hand out 12-step literature or mention 12-step groups to patients, this alone may not be sufficient to achieve a superior benefit (Kelly, Humphreys, & Yeterian, 2013). The types of TSF strategies used do matter, and the more intensive strategies, such as those evaluated herein, enhance participation rates and outcomes compared to the more routine 12-step-oriented TAU. Some of these strategies could be clinical linkage to existing members (e.g. Manning, et al. 2012; Timko, Debenedetti, & Billow, 2006), or active prescription of attendance versus leaving it to people to decide for themselves whether they want to attend AA (e.g. Walitzer, Dermen, & Barrick, 2009) (p. 33).

Throughout this *Planner* we cite references and include an appendix of clinical resources, including treatment manuals and books, which describe the how-to of delivering the EBT with high fidelity, and we recommend them for those who share the value of delivering treatment with the intent to maximize the client’s outcome.

At the beginning of each chapter, as we launch into the process of offering ideas for treatment interventions for the presenting problem, we have listed one Client Objective along with two associated Therapeutic Interventions

that emphasize the critical nature of a therapeutic relationship. These options were derived from the research on empirically supported relationship factors (e.g. Norcross, 2002) and disseminated most recently in Norcross & Lambert (2018) and Norcross & Wampold (2018). The relationship factors cited are as follows: *collaboration with the client* regarding the treatment process, agreement on the clear *goals and expectations* of therapy, demonstration of *consistent empathy* toward the client's feelings and struggles, verbalization of *positive regard* toward and *affirmation* of the client, and the collection and delivery of *client feedback* based on the client's appraisal of his/her progress in therapy (Norcross & Lambert, 2018; Norcross & Wampold, 2018). The body of research on relationship factors supports the conclusion that establishing a strong therapeutic relationship is necessary to optimize the treatment outcome. Accordingly, any of the other objectives and interventions that are selected to be included in a client's treatment plan should be integrated into and supported by an effective, foundational therapeutic relationship, and speaks to including this Client Objective and two associated Therapeutic Interventions in every treatment plan.

Each of the chapters in this edition has also been reviewed with the goal of integrating homework exercise options into the interventions. Many of the client homework exercise suggestions were taken from and can be found in the *Addiction Treatment Homework Planner* (Lenz, Finley, & Jongsma, 2014) and the *Adult Psychotherapy Homework Planner* (Jongsma & Bruce, 2014) along with a few from the *Adolescent Psychotherapy Homework Planner* (2014). You will find many more homework assignments suggested in this sixth edition of *The Addiction Treatment Planner* than in previous editions.

The bibliotherapy suggestions listed in Appendix A of this *Planner* have been significantly expanded and updated from previous editions. The appendix 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 it 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, SAMHSA within the US 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 multifaceted 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 recovery model 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. In addition, an intervention statement such as, “Help the client to see the new hope that addiction treatment brings to the resolution of interpersonal conflicts” from the “Suicidal Ideation” chapter is evidence that recovery model content, such as the principle of hope, 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 B.

We have done a bit of reorganizing of chapter content for this edition. We have renamed the “Unipolar Depression” chapter to become “Depression – Unipolar.” A new chapter entitled “Opioid Use Disorder” is returned as a separate chapter due to the epidemic use of this drug that is sweeping the country. “Opioids were involved in 46,802 overdose deaths in 2018 (69.5% of all drug overdose deaths). Two out of three (67.0%) opioid-involved overdose deaths involve synthetic opioids.” (Hedegaard, Miniño, & Warner, 2020; Wilson, Kariisa, Seth, Smith, & Davis, 2020). In recognition of the seriousness of this societal problem we have created a chapter to address this issue.

We have updated the Diagnostic Suggestions section at the end of each chapter by deleting all references to DSM-IV and ICD-9. Since the date for

mandatory use of *DSM-5 (ICD-10-CM)* codes and labels for billing purposes was October 2014, we have removed the transitional content of *DSM-IV*.

At the end of each chapter's list of objectives and interventions there is a reference to administration of a client satisfaction survey. Appendix D contains resource material for examples of various types of satisfaction assessment instruments.

Lastly, 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 cognitive, physiological, and behavioral components of anxiety and its treatment." 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 reflecting a behavioral activation objective: "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).

We hope you find these improvements to this sixth 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-IV-TR* 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 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 A contains a full bibliographic reference list of these materials. Many references to homework interventions are found in each chapter. The sources for these assignments can be found in the books listed in the general references at the beginning of Appendix A. For further information about self-help books, mental health professionals may wish to consult *Self-Help That Works: Resources to Improve Emotional Health and Strengthen Relationships* (Norcross et al., 2013).

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-IV-TR*. Despite arguments made 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-IV-TR* 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 Substance Use 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, 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 Planners* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, clinicians, and mental health community.

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SAMPLE TREATMENT PLAN

1. SUBSTANCE USE DISORDER

- Definitions:** Consistently uses alcohol or other mood-altering drugs until high, intoxicated, or passed out.
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.
Denies that chemical dependence is a problem, despite feedback from significant others that the use of the substance is negatively affecting him/her/they and others.
Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance.
Exhibits physical withdrawal symptoms (e.g. shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when going without the substance for any length of time.
Suspends important social, recreational, or occupational activities because they interfere with using the mood-altering drug.
- Goals:** Establish and maintain total abstinence, while increasing knowledge of the disease and the process of recovery.
Acquire the necessary 12-step skills and/or other skills to maintain long-term sobriety from all mood-altering substances and live a life free of substance abuse.

OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allows. (1, 2)

INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward he/she/they feeling safe to discuss his/her/their substance use and its impact on his/her/their life.

2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: work *collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of his/her/their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert & *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).
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| <ol style="list-style-type: none"> 2. Describe the type, amount, frequency, and history of substance abuse. (1) | <ol style="list-style-type: none"> 1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her/their use, signs and symptoms of use, and negative life consequences (e.g. social, legal, familial, and vocational problems). |
| <ol style="list-style-type: none"> 3. Participate in a medical evaluation to assess medical health and the medical consequences of substance use. (1) | <ol style="list-style-type: none"> 1. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence (include tests for HIV, hepatitis, and sexually transmitted diseases, if warranted). |
| <ol style="list-style-type: none"> 4. Explore and resolve ambivalence about entering treatment and changing substance use behavior. (1, 2, 3) | <ol style="list-style-type: none"> 1. Use the nondirective, client-centered, empathic style derived from motivational enhancement therapy (or supplement with "Assessing Readiness and Motivation" in the <i>Addiction Treatment Homework Planner</i> by Lenz, Finley, & Jongsma); explore the client's motivation for change and whether he/she/they are ready to take active steps or would benefit from continued motivational interviewing (see <i>Motivational Interviewing</i> by Miller & Rollnick; <i>Motivational Interviewing and Enhancement</i> by DiClemente, Van Orden, & Wright). |

2. Ask the client to make a list of the ways substance abuse has had a negative impact on his/her/their life (e.g. personally, medically, relationally, legally, vocationally, and socially) and the positive impact nonuse may have (or supplement with “Substance Abuse’s Negative Impact Versus Sobriety’s Positive Impact” in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce; or “Consequences of Continuing Addictive Lifestyles” in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma).
 3. Using a 12-Step Facilitation Therapy approach (see *Twelve-Step Facilitation Therapy Manual* by Nowinski et al.), assign the client to complete an Alcoholics Anonymous Step 1 paper admitting to powerlessness over mood-altering chemicals and present it in group therapy or to therapist for feedback (see *The Alcoholism & Drug Abuse Client Workbook* by Perkinson).
5. Commit self to an action plan directed toward termination or reduction of substance use. (1, 2, 3)
 1. 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.
 2. Assign the client to write a list of reasons to be abstinent from addiction (or supplement with “Alternatives to Addictive Behavior” in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma).
 3. Develop an abstinence contract with the client regarding the termination of the use of his/her/their drug of choice; process the client’s feelings related to the commitment.

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| <p>6. Attend Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings as frequently as necessary to support sobriety. (1)</p> <p>7. Verbalize increased knowledge of alcoholism and the process of recovery. (1)</p> <p>8. Cooperate with exploration of increasing satisfaction in areas of life that can support sobriety such as employment, recreation, and relationships. (1, 2, 3)</p> | <p>1. Recommend that the client attend AA or NA meetings and report on the impact of the meetings; process messages the client is receiving toward facilitating positive change.</p> <p>1. Conduct or assign the client to attend a chemical dependence didactic series to increase his/her/their knowledge of the patterns and effects of chemical dependence; ask him/her/them to identify several key points conveyed in each didactic and process these points.</p> <p>1. Facilitate development of a plan for the client to change his/her/their living situation to foster recovery (or supplement with “Assessing My Needs” in the <i>Addiction Treatment Homework Planner</i> by Lenz, Finley, & Jongsma); revisit routinely toward positive change in the client’s living situation.</p> <p>2. Teach the client skills necessary for finding a job, keeping a job, and improving satisfaction in a job setting (or supplement with “A Vocational Action Plan” in the <i>Adult Psychotherapy Homework Planner</i> by Jongsma & Bruce).</p> <p>3. Consistent with a community reinforcement approach, assist the client in identifying new alternative sources of reinforcement (e.g. reinforcing personal, social, and/or recreational activities) that do not involve substance use; reinforce gains; problem-solve obstacles toward sustained and effective implementation (See <i>A Community Reinforcement Approach to Addiction Treatment</i> by Meyers & Miller; or supplement with “Alternatives to Addictive Behavior” in the <i>Addiction Treatment Homework Planner</i> by Lenz, Finley, & Jongsma); use problem-solving and communication skills to overcome obstacles.</p> |
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9. Participate in behavioral couple's therapy designed to increase the non-substance-using partner's reinforcement of sobriety and to reduce relationship conflict.
(1, 2, 3, 4)
1. Develop a sobriety agreement 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 other interventions such as AA meetings, Antabuse use, "trust discussions"; and/or schedules a daily time to share thoughts and feelings.
2. Ask each partner to make a list of pleasurable activities that could be engaged in together to increase positive feelings toward each other (or supplement with "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce); process the list and assign implementation of one or more activities before the next session.
3. Teach the couple problem-solving skills (specifically defining 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 issues of conflict for the couple (or supplement with "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce).
4. In light of the recovery contract, review the client's sobriety experience and the couple's 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.

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| <p>10. Earn rewards by submitting drug-negative urine samples. (1)</p> <p>11. Learn and implement relapse prevention strategies. (1, 2)</p> | <p>1. Implement a prize-based contingency management system for drug-free living by rewarding the client's drug-negative urine samples with desired prizes starting at the low end of a \$1–\$100 range and increasing with continued abstinence (see <i>Contingency Management for Substance Abuse Treatment</i> by Petry).</p> <p>1. 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 supplement with “Aftercare Plan Components” in the <i>Adult Psychotherapy Homework Planner</i> by Jongsma & Bruce).</p> <p>2. Assist the client in developing a detailed, written recovery plan (e.g. treatment activities, daily routine, basic self-care, relationships, spirituality, work stress, finances, family issues, etc.) that will identify supports and strategies that will be used in maintaining sobriety (or supplement with “Personal Recovery Planning” in the <i>Addiction Treatment Homework Planner</i> by Lenz, Finley, & Jongsma).</p> |
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2. DIAGNOSIS

ICD-10-CM	DSM-5 Disorder, Condition, or Problem
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F10.20	Alcohol Use Disorder, Moderate
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ADULT-CHILD-OF-AN-ALCOHOLIC (ACA) TRAITS

BEHAVIORAL DEFINITIONS

1. Has a history of being raised in an alcoholic home, which resulted in having experienced emotional abandonment, role confusion, abuse, and a chaotic, unpredictable environment.
2. Has a history of unresolved childhood trauma caused by family addiction.
3. Reports an inability to trust others, share feelings, or talk openly about self.
4. Demonstrates an overconcern with the welfare of other people.
5. Passively submits to the wishes, wants, and needs of others; is too eager to please others.
6. Verbalizes chronic fear of interpersonal abandonment and desperately clings to relationships that can be destructive.
7. Tells other people what they think the other persons want to hear, rather than telling the truth.
8. Verbalizes persistent feelings of worthlessness and a belief that being treated with disrespect and shame is normal and to be expected.
9. Verbalizes feeling unwanted, unimportant, or unloved due to experiences of abandonment and abuse.
10. Reports strong feelings of panic and helplessness when faced with being alone.
11. Tries to fix other people before concentrating on his/her/their own needs.
12. Takes on the parental role in a relationship.
13. Reports feeling less worthy than those who have more stable lives.

LONG-TERM GOALS

1.

Implement a plan for recovery from addiction that reduces the impact of Adult-Child-of-an-Alcoholic (ACA) traits on sobriety.
2.

Decrease dependence on relationships while beginning to meet his/her/their own needs.
3.

Reduce the frequency of behaviors that are exclusively designed to please others.
4.

Choose partners and friends who are responsible, respectful, and reliable.
5.

Create recovery skills that reduce fears of abandonment, loss, and neglect.
6.

Understand the feelings that resulted from being raised in an ACA environment and reduce feelings of alienation.
7.

Create a spiritual program that allows for acceptance by a higher power.

SHORT-TERM OBJECTIVES



1.

Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow.
- (1, 2)

THERAPEUTIC INTERVENTIONS

1.

Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward him/her/their feeling safe to discuss his/her/their ACA behavior issues and their impact on his/her/their life.
2.

Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported

factors: work *collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of his/her/their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). ▽

2. Acknowledge the feelings of powerlessness that result from ACA traits and addiction. (3)
3. Probe the feelings of powerlessness that the client experienced as a child in the alcoholic home and explore similarities to his/her/their feelings when abusing chemicals (or assign the client to complete the Step 1 exercise in *The Alcoholism and Drug Abuse Client Workbook* by Perkinson).
3. Verbalize the relationship between being raised in an addictive family and how this behavior is repeated in addiction. (4)
4. Teach the client the relationship between his/her/their childhood experience in an addictive family and how this increased the likelihood of repeating the addictive behavior pattern as an adult (or assign the client to complete the "Understanding Family History" exercise in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma).
4. Complete psychological testing or objective questionnaires for assessing traits associated with being an adult child of an alcoholic. (5)
5. Administer to the client psychological instruments designed to objectively assess the strength of traits associated with being an adult child of an alcoholic (e.g. Symptom Checklist-90-Revised, Children of Alcoholics Screening Test); give the client feedback regarding the results of the assessment and readminister if necessary to assess treatment progress.

4 THE ADDICTION TREATMENT PLANNER

5. Verbalize the rules of “don’t talk, don’t trust, don’t feel,” which were learned as a child, and how these rules have made interpersonal relationships more difficult. (6, 7)
6. Verbalize an understanding of how ACA traits contributed to addiction. (8, 9)
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. (10, 11, 12, 13)
6. Explore how the dysfunctional family rules led to chronic fear and an escape into addiction.
7. Educate the client about the ACA rules of “don’t talk, don’t trust, and don’t feel”; explain how these rules make healthy relationships more difficult.
8. Have the client list five ways that ACA traits led to addiction (or supplement with “Addressing ACA Traits in Recovery” from the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma).
9. Assist the client in identifying his or her ACA traits and the relationship between ACA traits and addiction.
10. 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).
11. Assess the client for evidence of research-based correlated disorders (e.g. antisocial behavior, oppositional defiant disorder with attention-deficit/hyperactivity disorder [ADHD], depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g. increased suicide risk when comorbid depression is evident).

12. 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.
13. 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 the causes of the fear of abandonment that were experienced in the alcoholic home. (14, 15)
14. Probe the client's fear of violence, abandonment, unpredictability, and embarrassment when the parent was mentally unstable or abusing chemicals.
15. Explore specific situations when the client experienced fear of abandonment, mental or physical abuse, and/or feelings of rejection during childhood.
9. Identify how the tendency to take care of others in interpersonal relationships is related to maintaining a feeling of security and control. (16, 17)
16. Assist the client in understanding how his/her/their early childhood experiences led to fears of abandonment, rejection, neglect, and an assumption of the caretaker role, which is detrimental to intimate relationships.
17. Assist the client in identifying the many ways in which he/she/they take on the parental role of caregiver.
10. Share the feeling of worthlessness that was learned in the alcoholic home, and directly relate this feeling to abuse of substances as a coping mechanism. (18, 19)
18. Explore the client's feelings of worthlessness and shame, assessing specific painful situations.
19. Teach the client how low self-esteem results from being raised in an alcoholic home, due to experiencing emotional rejection, broken promises, abuse, neglect, poverty, and lost social status.

6 THE ADDICTION TREATMENT PLANNER

11. List 10 reasons for increased feelings of self-worth. (20, 21)
12. Identify the pattern in the alcoholic family of being ignored or punished when honest feelings were shared. (7, 22)
13. List five qualities and behaviors that should be evident in others before interpersonal trust can be built. (23)
14. Increase the frequency of telling the truth rather than saying only what the client thinks the other person wants to hear. (24, 25)
20. Assign the client to list his/her/their positive traits and accomplishments; reinforce these as a foundation for building self-esteem (or supplement with “Acknowledging My Strengths” in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce).
21. Emphasize to the client his/her/their inherent self-worth as a human being and show the benefits of using a higher power in recovery.
7. Educate the client about the ACA rules of “don’t talk, don’t trust, don’t feel”; explain how these rules make healthy relationships more difficult.
22. Probe how the client’s family responded to expressions of feelings, wishes, and wants and why it became dangerous for the client to share feelings with others (or assign the client to complete the “Understanding Family History” exercise in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma).
23. Assist the client in developing a set of character traits to be sought in others (e.g. honesty, sensitivity, open mindedness, kindness) that qualify them as trustworthy.
24. Teach the client that the behavior of telling other people what we think they want to hear rather than speaking the truth is based on fear of rejection, which was learned in the alcoholic home; use modeling, role-playing, and behavior rehearsal to teach the client more honest communication skills.
25. Assign the client to keep a journal of incidents in which he/she/they told the truth rather than saying only what others wanted to hear.

15. List the steps to effectively and independently solving problems. (26)
16. Acknowledge the resistance to sharing personal problems; share at least one problem in each therapy session. (7, 27, 28, 29)
17. Verbalize an understanding of how ACA traits contribute to choosing partners and friends that have problems and need help. (16, 30)
26. Teach the client problem-solving skills (e.g. identify the problem, brainstorm alternate solutions, examine the advantages and disadvantages of each option, select an option, implement a course of action, and evaluate the result); role-play solving a current problem in his/her/their life (or assign “Applying Problem Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce).
7. Educate the client about the ACA rules of “don’t talk, don’t trust, don’t feel”; explain how these rules make healthy relationships more difficult.
27. Probe how the client’s family responded to expressions of feelings, wishes, and wants and why it became dangerous for the client to share feelings with others.
28. Educate the client about healthy interpersonal relationships based on openness, respect, and honesty; explain the necessity of sharing feelings to build trust and mutual understanding (or assign the client to complete the honesty exercise in *The Alcoholism and Drug Abuse Client Workbook* by Perkinson).
29. Explore the client’s pattern of resistance to sharing personal problems and preferring, instead, to focus on helping others with their problems.
16. Assist the client in understanding how his/her/their early childhood experiences led to fears of abandonment, rejection, neglect, and an assumption of the caretaker role, which is detrimental to intimate relationships.

8 THE ADDICTION TREATMENT PLANNER

30. Help the client to understand that his/her/their strong need to help others is based on low self-esteem and the need for acceptance, which was learned in the alcoholic family of origin; relate this caretaking behavior to choosing friends and partners who are chemically dependent and/or psychologically disturbed.
18. Initiate the encouragement of others in recovery, to help reestablish a feeling of self-worth. (31, 32)
31. Teach the client that active involvement in a 12-step recovery group can aid in building trust in others and confidence in oneself (or assign the client to complete the Step 12 exercise in *The Alcoholism and Drug Abuse Client Workbook* by Perkinson).
32. Assist the client in developing an aftercare plan that is centered on regular attendance at Adult Children of Alcoholics, Alcoholics Anonymous, and Narcotics Anonymous (ACA/AA/NA) meetings.
19. List reasons why regular attendance at recovery group meetings is necessary to arrest ACA traits and addiction. (33)
33. Assist the client in listing reasons why 12-step recovery group attendance is helpful to overcome ACA traits.
20. Discuss fears that are related to attending recovery group meetings and develop specific written plans to deal with each fear. (34)
34. Probe the relationship between ACA traits and the fear of attending recovery group meetings; assist the client in developing coping strategies to cope with the fear (e.g. give self-positive messages regarding self-worth, use relaxation techniques to reduce tension, use meditation to induce calm and support from a higher power [or assign “Safe and Peaceful Place Meditation” exercise in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma or “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce]).

21. Verbalize how a recovery group can become the healthy family that one never had. (35, 36, 37)
22. List five ways in which belief in, and interaction with, a higher power can reduce fear and increase self-worth in recovery. (38, 39)
23. Verbalize the feeling of serenity that results from turning out-of-control problems over to a higher power. (40)
35. Teach the client that active involvement in a recovery group can aid in building trust in others and confidence in oneself.
36. Discuss how the home recovery group of ACA/AA/NA can function as the healthy family the client never had; help him/her/them realize why he/she/they need such a family to recover (or assign the client to complete the Step 12 exercise in *The Alcoholism and Drug Abuse Client Workbook* by Perkinson).
37. Educate the client about the family atmosphere in a home ACA/AA/NA recovery group, and how helping others can aid in recovery and reestablish a feeling of worth.
38. Teach the client how faith in a higher power can aid in recovery and arrest ACA traits and addiction (or assign the client to complete the Step 2 exercise in *The Alcoholism and Drug Abuse Client Workbook* by Perkinson).
39. Assign the client to read the Adult Children of Alcoholics *Red Book* and the Alcoholics Anonymous *Big Book* on the topic of spirituality and the role of a higher power; process the material in an individual or group therapy session.
40. Review problematic circumstances in the client's life that could be turned over to a higher power to increase serenity (or supplement with "Understanding Spirituality" or "Finding a Higher Power That Makes Sense" in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma).

10 THE ADDICTION TREATMENT PLANNER

24. Practice assertiveness skills and share how these skills were used in interpersonal conflict. (41, 42)
25. Share the personal experiences of each day with one person that day. (43, 44)
26. Cooperate with a physician's evaluation for psychopharmacological intervention. (45)
27. Take medications as prescribed, and report on their effectiveness and side effects. (46, 47)
28. Develop a five-year plan to recover from substance abuse and ACA traits. (48)
41. Use modeling, behavior rehearsal, and role-playing to teach the client healthy, assertive skills (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce); apply these skills to several current problem situations, and then ask the client to journal his/her/their assertiveness experiences.
42. Teach the client the assertive formula of "I feel ____ when you _____. I would prefer it if ____"; role-play several applications in his/her/their life and then assign him/her/them to use this formula three times per day.
43. Teach the client the *share check* method of building trust, in which the degree of shared information is related to a proven level of trustworthiness; use behavior rehearsal of several situations in which the client shares feelings.
44. Review and reinforce instances when the client has shared honestly and openly with a trustworthy person.
45. Refer the client to a physician to evaluate whether psychopharmacological interventions are warranted.
46. Medical staff administers medications to the client as prescribed.
47. Monitor the client's medications for effectiveness and side effects.
48. Assist in the client developing a five-year plan to recover from substance abuse and ACA traits (or assign the client to complete the Personal Recovery Plan exercise in *The Alcoholism and Drug Abuse Client Workbook* by Perkinson).

29. Complete a survey to assess the degree of satisfaction with treatment. (49)	49. Administer a survey to assess the client's degree of satisfaction with treatment.
____.	____.
_____	_____
____.	____.
_____	_____
____.	____.
_____	_____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	DSM-5 Disorder, Condition, or Problem
F34.1	Persistent depressive disorder
F41.1	Generalized anxiety disorder
F41.9	Unspecified anxiety disorder
F43.10	Posttraumatic stress disorder
Z62.820	Parent–child relational problem
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.9	Unspecified personality disorder

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

ANGER

BEHAVIORAL DEFINITIONS

1. Has a history of explosive, aggressive outbursts, particularly when intoxicated, that lead to assaultive acts or destruction of property.
2. Abuses substances to cope with angry feelings and to relinquish responsibility for aggression.
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 verbal, 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.

LONG-TERM GOALS

1. Maintain a program of recovery that is free of addiction and violent behavior.
2. Learn and implement anger management skills to reduce the level of anger and irritability that accompanies it.
3. Increase honest, appropriate, respectful, and direct communication using assertiveness and conflict resolution skills.
4. Develop an awareness of angry thoughts, feelings, and actions, clarifying origins of, and learning alternatives to aggressive anger.
5. Decrease the frequency, intensity, and duration of angry thoughts, feelings, and actions and increase the ability to recognize and assertively express frustration and resolve conflict.
6. Implement cognitive behavioral skills necessary to solve problems in a more constructive manner.

SHORT-TERM OBJECTIVES

- ▼ 1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)
2. Identify situations, thoughts, and feelings associated with anger, angry verbal, and/or behavioral actions, and the targets of those actions. (3)
3. Complete psychological testing or objective questionnaires for assessing anger expression. (4)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward his/her/their feeling safe to discuss his/her/their anger control issues and their impact on his/her/their life. ▼
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: work *collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of his/her/their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). ▼
3. 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/their anger responses.
4. 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; readminister as indicated to assess treatment response.

4. Cooperate with a complete medical evaluation. (5)
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)
5. Arrange for a medical evaluation to rule out nonpsychiatric medical and substance-induced etiologies for poorly controlled anger (e.g. brain injury, tumor, elevated testosterone levels, stimulant use).
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 attention-deficit/hyperactivity disorder [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).

- ▼^{EB} 6. Explore the consequences of anger, motivation and willingness to participate in treatment, and agree to participate to learn new ways to think about and manage anger. (10, 11, 12)
- ▼^{EB} 7. Verbalize an understanding of how angry thoughts and feelings can lead to increased risk of addiction. (13, 14)
- ▼^{EB} 8. Agree to learn new alternative ways to recognize and manage anger. (15)
10. As part of exploring the client's decisional balance to engage in treatment, 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 supplement with "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma & Bruce. ▼^{EB}
11. As part of exploring the client's decisional balance to engage in treatment, ask the client to list and discuss ways anger has negatively affected his/her/their daily life (e.g. hurting others or self, legal conflicts, loss of respect from self and others, destruction of property); process this list. ▼^{EB}
12. Use motivational interviewing techniques toward clarify the client stage of change, moving the client toward the action stage in which he/she/they agree to take specific actions to more effectively conceptualize and manage anger (see *Motivational Interviewing* by Miller & Rollnick). ▼^{EB}
13. Use guided discovery (e.g. Socratic questioning) to educate the client about his/her/their tendency to engage in addictive behavior as a means of relieving uncomfortable feelings; develop a list of several instances of occurrence. ▼^{EB}
14. Teach the client about high-risk triggers of substance use including strong negative emotions, social pressure, interpersonal conflict, strong positive emotions, and other stressors; discuss examples of how triggers can lead to substance use, the consequences of this pattern, and the availability of alternatives in preventing and managing the risk. ▼^{EB}
15. Confirm with the client that he/she/they agree to try to learn new ways to recognize and manage anger. ▼^{EB}