PracticePlanners®

Arthur E. Jongsma, Jr., Series Editor

Companion to *The Adult Psychotherapy Progress Notes Planner, 6th Edition* and *Homework Planner, 6th Edition*

SIXTH EDITION

The Complete Adult Psychotherapy TREATMENT PLANNER

This timesaving resource features:

- A wide array of best practice Treatment Plan components for 45 behaviorally based presenting problems
- Over 8,000 prewritten Goals, Objectives, and Interventions plus Suggested Diagnoses
- A step-by-step guide to writing treatment plans to satisfy most accrediting agencies and third party payors
- A description of how to easily modify behavioral Objectives to make them more Measurable to satisfy some reviewers
- Evidence-Based Interventions required by many funding sources and private insurers are highlighted

ARTHUR E. JONGSMA, JR., L. MARK PETERSON, AND TIMOTHY J. BRUCE

WILEY

Table of Contents

Practice*Planners*® Series

Treatment Planners

The Complete Adult Psychotherapy Treatment Planner, Fifth Edition
The Child Psychotherapy Treatment Planner, Fifth Edition
The Adolescent Psychotherapy Treatment Planner, Fifth Edition
The Addiction Treatment Planner, Fifth Edition
The Continuum of Care Treatment Planner
The Couples Psychotherapy Treatment Planner, Second Edition
The Employee Assistance Treatment Planner
The Pastoral Counseling Treatment Planner
The Older Adult Psychotherapy Treatment Planner, Second Edition
The Behavioral Medicine Treatment Planner
The Group Therapy Treatment Planner
The Gay and Lesbian Psychotherapy Treatment Planner
The Family Therapy Treatment Planner, Second Edition
The Severe and Persistent Mental Illness Treatment Planner, Second Edition
The Mental Retardation and Developmental Disability Treatment Planner
The Social Work and Human Services Treatment Planner
The Crisis Counseling and Traumatic Events Treatment Planner, Second Edition
The Personality Disorders Treatment Planner
The Rehabilitation Psychology Treatment Planner
The Special Education Treatment Planner
The Juvenile Justice and Residential Care Treatment Planner
The School Counseling and School Social Work Treatment Planner, Second Edition
The Sexual Abuse Victim and Sexual Offender Treatment Planner
The Probation and Parole Treatment Planner
The Psychopharmacology Treatment Planner
The Speech Language Pathology Treatment Planner
The Suicide and Homicide Treatment Planner
The College Student Counseling Treatment Planner
The Parenting Skills Treatment Planner
The Early Childhood Intervention Treatment Planner
The Co Occurring Disorders Treatment Planner
The Complete Women's Psychotherapy Treatment Planner
The Veterans and Active Duty Military Psychotherapy Treatment Planner

Progress Notes Planners

The Child Psychotherapy Progress Notes Planner, Fifth Edition
The Adolescent Psychotherapy Progress Notes Planner, Fifth Edition
The Adult Psychotherapy Progress Notes Planner, Fifth Edition
The Addiction Progress Notes Planner, Fifth Edition
The Severe and Persistent Mental Illness Progress Notes Planner, Second Edition
The Couples Psychotherapy Progress Notes Planner, Second Edition
The Family Therapy Progress Notes Planner, Second Edition
The Veterans and Active Duty Military Psychotherapy Progress Notes Planner

Homework Planners

Couples Therapy Homework Planner, Second Edition
Family Therapy Homework Planner, Second Edition
Grief Counseling Homework Planner
Group Therapy Homework Planner
Divorce Counseling Homework Planner
School Counseling and School Social Work Homework Planner, Second Edition
Child Therapy Activity and Homework Planner
Addiction Treatment Homework Planner, Fifth Edition
Adolescent Psychotherapy Homework Planner, Fifth Edition
Adult Psychotherapy Homework Planner, Fifth Edition
Child Psychotherapy Homework Planner, Fifth Edition
Parenting Skills Homework Planner
Veterans and Active Duty Military Psychotherapy Homework Planner

Client Education Handout Planners

Adult Client Education Handout Planner
Child and Adolescent Client Education Handout Planner
Couples and Family Client Education Handout Planner

Complete Planners

The Complete Depression Treatment and Homework Planner
The Complete Anxiety Treatment and Homework Planner

The Complete Adult Psychotherapy Treatment Planner

Sixth Edition

Arthur E. Jongsma, Jr.
L. Mark Peterson
Timothy J. Bruce

WILEY

This edition first published 2021.

Edition History

John Wiley & Sons, Inc. (5e, 2014); John Wiley & Sons, Inc. (4e, 2006); John Wiley & Sons, Inc. (3e, 2003); John Wiley & Sons, Inc. (2e, 1999); John Wiley & Sons, Inc. (1e, 1995)

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

Editorial Office
111 River Street, Hoboken, NJ 07030, USA

For details of our global editorial offices, customer services, and more information about Wiley products visit us at www.wiley.com.

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.

Library of Congress Cataloging in Publication Data

Names: Jongsma, Arthur E., Jr., 1943- author. | Peterson, L. Mark, author. | Bruce, Timothy J., author.

Title: The complete adult psychotherapy treatment planner / Arthur E. Jongsma, L. Mark Peterson, Timothy J. Bruce.

Description: Sixth edition. | Hoboken : Wiley, [2021] | Series: Practiceplanners. | Includes bibliographical references.

Identifiers: LCCN 2020025450 (print) | LCCN 2020025451 (ebook) | ISBN 9781119629931 (paperback) | ISBN 9781119629986 (adobe pdf) | ISBN 9781119629924 (epub)

Subjects: LCSH: Psychotherapy—Handbooks, manuals, etc. | Medical records—Handbooks, manuals, etc. | Adulthood--Psychological aspects—Handbooks, manuals, etc. | Mental illness—Treatment—Handbooks, manuals, etc.

Classification: LCC RC480.5 .J663 2021 (print) | LCC RC480.5 (ebook) | DDC 616.89/14—dc23

LC record available at https://lccn.loc.gov/2020025450
LC ebook record available at https://lccn.loc.gov/2020025451

Cover Design: Wiley
Cover Images: © Ryan McVay/Getty Images

PRACTICE*PLANNERS*® 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 Practice*Planners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

- The Practice*Planners*® 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 treatment (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 customizable treatment plan along with optional integrated progress notes and homework assignments. TheraScribe is available by calling 616.776.1745. Also, see TheraScribe.com for more information.

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. Although 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 based just on "best practice" but 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. Dr. Bruce has used his depth of knowledge regarding evidence‐supported treatment to shape and inform the content of the last three editions of *Adult, Adolescent, Child,* and *Addiction Psychotherapy Treatment Planners*.

I am pleased to announce that after the current revisions of these planners, Dr. Bruce will be assuming the role of Series Editor as I move toward retirement. I make this move with the utmost confidence that the Practice*Planners* series will be in very capable hands. Tim is the consummate psychologist who knows the research literature on psychotherapy, is a compassionate and effective therapist, and whose integrity and ethics are of the highest caliber. I am always thankful for Tim Bruce and his many gifts.

It has now been 25 years since my first Treatment Planner book was published by Wiley. The series has grown to 53 books and my relationship with the highly regarded John Wiley & Sons publishing house continues to be strong. In a day of pervasive quickly fading loyalties I count it a blessing for us to be trusted partners for all these years. Thank you to my current editor Darren along with Veronika and Monica for your great professionalism.

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

Finally, every ship needs a strong rudder to stay on course. My rudder for all the vagaries of life is my wife, Judy, and we both keep seeking God's will as our ultimate map.

AEJ

I am more than fortunate to have been invited some 15 years ago by Dr. Art Jongsma to work with him on his well‐known and highly regarded Practice*Planners* series and to have been welcomed by his coauthors with whom I have had the pleasure of working, including our coauthor on this volume, Mark Peterson. As a reader of this book, you probably appreciate that Dr. Jongsma's treatment planners are works of enormous value to practicing clinicians as well as terrific educational tools for "students" of our profession. I remember reading my first treatment planner and thinking, "Wow! Art has done something here, and done it very well!" Since then, I have come to know Art, his family, his friends, his thoughts, his values, his love of my paella, the way he lives his life, and I can tell you that my first impression was correct. As a psychologist, husband, father, colleague, you name it, Art Jongsma has done something here and done it very well. I am more than fortunate to have him as a colleague and friend. As Art noted in his acknowledgment, he recently told me of his plans to "move toward" retirement and asked me if I would take stewardship of, take care of, his brainchild and invaluable contribution to our field. To say the least, I was honored, but also simultaneously humbled. By this, I mean that I am no Art Jongsma, but I will do my best to keep this series of the quality and value that he has. Thank you again, Art, for everything.

I would also like to thank the team at John Wiley & Sons. Executive Editor Darren Lalonde, Senior Project Editor Daniel Finch, Senior Manager Veronika Yefremenko, and their staff who were expert, kind, supportive, and professional in managing what I think we should call a highly effective international coordination of the writing and publishing process. It was a pleasure.

Lastly, I would like to thank my wife of 39 years, Lori, our son Logan, daughter‐in‐law Cassy, and daughter Madeline, for all they do. I am more than fortunate. Thank you.

TJB

ABOUT THE COMPANION WEBSITE

This book is accompanied by a companion website.
www.wiley.com\go\jongsma\adulttp6e

This website includes:

- Appendix E: References to Empirical Support for Evidence‐Based Chapters in the Complete Adult Psychotherapy Treatment Planner, 6th Edition

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

INTRODUCTION

ABOUT PRACTICE*PLANNERS*® 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 provides 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 *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (*DSM 5*™) diagnosis.

As with the rest of the books in the Practice*Planners*® 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 SIXTH EDITION COMPLETE *ADULT PSYCHOTHERAPY TREATMENT PLANNER*

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

- Updated with new and revised evidence-based Objectives and Interventions from the research literature
- Revised, expanded, and updated References to Clinical Resources for Evidence-Based Chapters appendix
- Moved a Revised Appendix for References to Empirical Support online as found at: www.wiley.com/go/jongsma/adulttp6e
- More suggested homework assignments integrated into the Interventions
- Expanded and updated self-help book list in the Bibliotherapy appendix
- Addition of new chapters on Loneliness and on Opioid Use Disorder
- Unipolar Depression chapter has been renamed Depression—Unipolar and Sexual Identity Confusion chapter has been renamed Sexual Orientation Confusion
- Suicidal Ideation has been added to the list of evidence-based chapters with new research content inserted
- Integrated *DSM 5* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter and all transition references to *DSM IV* have been removed

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, 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 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 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 may have demonstrated efficacy, factors such as the individual psychologist (e.g., Wampold, 2001), the treatment relationship (e.g., Norcross, 2019), and the client (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 titled *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 evidence-based practice 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 evidence-based practice is defined (e.g., Dimidjian, 2019; Norcross, Hogan, Koocher, & Maggio, 2017). Evidence-based practice guidelines informing the selection process include those from the American Psychological Association, 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/adulttp6e. In addition to these references to empirical support, we have also included a References to Clinical Resources appendix. 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 evidence-based practice 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 not have 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 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
- 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 evidence-based practices 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.

Each of the chapters in this edition provides options to integrate homework exercises 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, 2013). You will find more homework assignments suggested in this sixth edition of the *Adult Psychotherapy Treatment Planner* than in previous editions.

The Bibliotherapy Suggestions appendix of this *Planner* has been expanded and updated from previous editions. It includes classics, recently published offerings, as well as more recent editions of books cited in our earlier editions. All 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 the

chapter's content listed in this appendix.

In its final report titled *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 (SAMHSA, 2004, p. 13)

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, "Assist the client in finding positive, hopeful things in his/hertheir life at the present time" 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 Unipolar Depression chapter as Depression—Unipolar. This chapter continues to be distinct from the chapter written for Bipolar Disorder—Depression. Bipolar Disorder—Mania continues 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 evidence.based treatment (EBT) symbol may or may not be present for the same content. This is done to indicate that the particular EBT currently 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 online at www.wiley.com/go/jongsma/adulttp6e.

In regard to new presenting problems to add to this *Planner*, we debated whether we should add a chapter on Opioid Use Disorder because it is a continuing national addiction problem of major proportions. We decided that, although the chapter on Substance Use contains content that is directly applicable to opioid use treatment, there is enough content unique to Opioid Use treatment to call for the addition of this new chapter. We borrowed some content from the Opioid Dependence chapter found in *The Veterans and Active Duty Military Psychotherapy Treatment Planner* by Moore and Jongsma (2015) and updated it with more recent treatment research results. The other new chapter for this edition focuses on Loneliness as a primary presenting problem. Interventions deal with social anxiety, depression, low self.esteem, grief, developmental communication issues, and personality disorder factors. Despite our current culture's preoccupation with "social media," hosts of people feel isolated and afraid to or do not know how to "reach out and touch someone." We hope this chapter will help clinicians effectively treat clients with this problem.

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 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. Similarly, 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).

We hope you find these improvements to this sixth edition of the *Adult Treatment 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 deal with only 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 providers to write other interventions reflecting their 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, including these two popular choices: *Read Two Books and Let's Talk Next Week: Using Bibliotherapy in Clinical Practice* by 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 *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 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 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.

REFERENCES AND FURTHER READING

American Psychiatric Association. *American Psychiatric Association practice guidelines*. American Psychiatric Association. http://psychiatryonline.org/guidelines.aspx.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

American Psychological Association. *APA clinical practice guidelines*. American Psychological Association. https://www.apa.org/about/offices/directorates/guidelines/clinical-practice.

American Psychological Association Division 12: Society of Clinical Psychology. *American Psychological Association division 12 website on research supported psychological treatments*. https://www.div12.org/treatments.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285.

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self healing*. American Psychological Association.

Cochrane Collaboration Reviews. http://www.cochrane.org/.

David, D., Lynn, S. J., & Montgomery, G. H. (Eds.). (2018). *Evidence based psychotherapy: The state of the science and practice*. Wiley.

Dimidjian, S. (Ed.) (2019). *Evidence based practice in action*. Guilford Press.

Goldfried, M. R. (2019). Obtaining consensus in psychotherapy: What holds us back? *American Psychologist*, *74*(4), 484–496.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academy Press. https://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the.

Jongsma, A. E. (2013). *Adult psychotherapy homework planner* (3rd ed.). John Wiley and Sons.

Jongsma, A. (2005). Psychotherapy treatment plan writing. In G. P. Koocher, J. C. Norcross, & S. S. Hill (Eds.), *Psychologists' desk reference* (2nd ed., pp. 232–236). Oxford University Press.

Jongsma, A. E., & Bruce, T. J. (2010–2012). *The evidence based psychotherapy treatment planning* [DVD-based series]. John Wiley & Sons. http://www.Wiley.com/go/ebtdvds.

Moore, B. A., & Jongsma, A. E. (2015). *The veterans and active duty military psychotherapy treatment planner*. John Wiley and Sons.

Nathan, P. E., & Gorman, J. M. (Eds.). (2015). *A guide to treatments that work* (4th ed.). Oxford University Press.

National Institute on Drug Abuse. https://www.drugabuse.gov.

National Institute for Health and Clinical Excellence (NICE). http://www.nice.org.uk.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (Final report. DHHS Publication No. SMA-03-3832). New Freedom Commission on Mental Health. https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html.

Norcross, J. C. (Ed.). (2019). *Psychotherapy relationships that work* (3rd ed.). Oxford University Press.

Norcross, J. C., Hogan, T. P., & Koocher, G. P., & Maggio, L. A. (2017). *Clinician's guide to evidence based practices: Behavioral health and the addictions*. Oxford University Press.

Norcross, J. C., Santrock, J. W., Campbell, L. F., Smith, T. P., Sommer, R., & Zuckerman, E. L. (2003). *Authoritative guide to self help resources in mental health, revised edition*. Guilford Press.

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*. SAMHSA.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Lawrence Erlbaum.

SAMPLE TREATMENT PLAN

ANXIETY

Behavioral Definitions

- Excessive and/or unrealistic worry that is difficult to control occurring more days than not for at least 6 months about two or more 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).

Long-Term 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	INTERVENTIONS
1. EB Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as	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 feeling safe to discuss generalized anxiety and its impact on his/her/their life. EB 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

comfort and trust allows.	client's perception of his/her/their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross and Lambert and Vol. 2 by Norcross and Wampold). EBP
2. Describe situations, thoughts, feelings, and actions associated with anxieties and worries; their impact on functioning; and attempts to resolve them.	3. Ask the client to describe 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 anxiety symptoms (consider using a structured interview such as the *Anxiety and Related Disorders Interview Schedule for the DSM 5* by Brown and Barlow.)
3. EBP Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment.	4. Discuss how anxiety typically involves excessive worry about unrealistically appraised threats, various bodily expressions of overarousal, 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). EBP 5. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduce overarousal, eliminate unnecessary avoidance, and reengage in rewarding activities. EBP 6. Assign the client to read psychoeducational materials as a bibliotherapy adjunct to in-session work (e.g., *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow; *The Anxiety and Worry Workbook* by Clark and Beck. EBP
4. EBP Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms.	7. Teach the client calming/relaxation/mindfulness 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 daily life (see *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; or supplement with *The Relaxation and Stress Reduction Workbook* by Davis, et al.). EBP 8. Assign the client homework in which they practice calming/relaxation/mindfulness skills daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success; find solutions for obstacles toward sustained implementation (or supplement with "Deep Breathing Exercise" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBP
5. Learn and implement a strategy to limit the association between various environmental settings and worry, delaying the worry until a designated "worry time."	9. Explain the rationale and teach a worry time intervention in which the client postpones interacting with worries until a designated time and place; use worry time for exposure (repeating worry toward extinction) and/or the application of problem-solving skills to address worries; agree upon and implement a worry time with the client. EBP 10. 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 supplement with "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; find solutions for obstacles toward sustained implementation. EBP
6. EBP Verbalize an understanding of the role that thinking plays in worry, anxiety, and avoidance.	11. Assist the client in analyzing worries by examining potential biases such as the probability of the negative expectation occurring, the real consequences of it occurring, ability to control the outcome, the worst possible outcome, and ability to accept it (or supplement with "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework Planner* by Jongsma; *Cognitive Therapy of Anxiety Disorders* by Clark and Beck). EBP
7. EBP Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk.	12. Using techniques from cognitive behavioral therapies including intolerance of uncertainty and metacognitive therapies explore the client's self-talk, underlying assumptions, schema, or metacognition that mediate anxiety; assist the client in challenging and changing biases; conduct behavioral experiments to test biased versus unbiased predictions toward dispelling unproductive worry and increasing self-confidence in addressing the subject of worry (see *Cognitive Therapy of Anxiety Disorders* by Clark and Beck; *Metacognitive Therapy for Anxiety and Depression* by Wells). EBP 13. Assign the client a homework exercise to identify fearful self-talk, identify biases in the self-talk, generate alternatives, and test them through behavioral experiments (or supplement with "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. EBP

DIAGNOSIS

F41.1	Generalized Anxiety Disorder

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 adherence 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. Learn and implement anger management skills to reduce the level of anger and irritability that accompanies it.
2. Increase honest, appropriate, respectful, and direct communication using 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 assertively 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 the rights of others to have their own thoughts and feelings.

—. _____

—. _____

—. _____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. EBP Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow (1, 2).	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 feeling safe to discuss anger control issues and their impact on the client's life. EBP 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 and Lambert and *Vol. 2* by Norcross and Wampold). EBP
2. Identify situations, thoughts, and feelings associated with anger, angry verbal and/or behavioral actions, and the targets of those actions. (3)	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 anger responses.
3. Complete psychological testing or objective questionnaires for assessing anger expression. (4)	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. 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).

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 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).

6. EB V-.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)

10. 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.); assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB V-
11. Ask the client to list and discuss ways anger has negatively affected daily life (e.g., hurting others or self, legal conflicts, loss of respect from self and others, destruction of property); process this list. EB V-
12. Use motivational interviewing techniques toward clarifying the client's stage of change, moving the client toward the action stage in which the client agrees to take specific actions to conceptualize and manage anger more effectively (see *Motivational Interviewing* by Miller and Rollnick). EB V-

7. EB V-.Cooperate with a medication evaluation for possible treatment with psychotropic medications to assist in anger control; take medications consistently, if prescribed. (13, 14)

13. Assess the client for the need and willingness to take psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation and prescription of medication, if needed. EB V-
14. Monitor the client's psychotropic medication adherence, side effects, and effectiveness; confer as indicated with the prescriber. EB V-

8. EB V-.Keep a daily journal of persons, situations, and other triggers of anger; record thoughts, feelings, and actions taken or not. (15, 16)

15. Ask the client to self-monitor, keeping a daily journal in which the client documents persons, situations, thoughts, feelings, and actions associated with moments of anger, irritation, or disappointment (or supplement with "Anger Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma); routinely process the journal toward helping the client understand his/her/their own contributions to generating anger. EB V-
16. Assist the client in generating a list of anger triggers; process the list toward helping the client understand the causes and expressions of anger. EB V-

9. EB V-.Verbalize increased awareness of anger expression patterns, their causes, and their consequences. (17, 18)

17. Convey a model of anger that involves 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 aggression), and that can be understood and changed (see *Anger Management* by Kassinove and Tafrate; *Overcoming Situational and General Anger* by Deffenbacher and McKay). EB V-
18. 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. EB V-

10. EB V-.Verbalize an understanding of how the treatment is designed to help regulate anger, effectively manage it, and improve quality of life. (19)

19. 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 understanding. EB V-

11. EB V-.Read material that supplements the therapy by improving understanding of anger, anger control problems, and their management. (20)

20. Assign the client reading material that educates him/her about anger and its management (e.g., *Overcoming Situational and General Anger: Client Manual* by Deffenbacher and McKay; *Anger Management for Everyone* by Kassinove and Tafrate); process and revisit relevant themes throughout therapy to help the client consolidate understanding of relevant concepts. EB V-

12. EB V-.Learn and implement calming and coping strategies as part of an overall approach to managing anger. (21)

21. As part of a larger personal and interpersonal skill set, teach the client tailored calming techniques (e.g., progressive muscle relaxation, breathing induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation, mindful breathing) for reducing chronic and acute arousal that accompanies anger expression (or supplement with "Deep Breathing Exercise" in the *Adult Psychotherapy Homework Planner* by Jongsma. EB V-

13. EB V-.Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a more measured response. (22, 23, 24)

22. Use cognitive therapy techniques to explore the client's self-talk that mediates angry feelings and actions (e.g., demanding expectations reflected in should, must, or have-to statements); identify, challenge, and change biased self-talk, assist him/her in generating appraisals that correct for the biases and facilitate a more flexible and temperate response to frustration; explore underlying assumptions and schema if needed. Combine new self-talk with calming skills as part of a coping skills set for managing anger. EB V-
23. Assign the client a homework exercise to identify angry self-talk and generate alternatives that help regulate angry reactions; review; reinforce success, problem-solve obstacles toward sustained and effective implementation (or supplement with "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB V-
24. Role-play the use of calming and cognitive coping skills to visualized anger-provoking scenes, moving from low- to

	high-anger scenes. Assign the implementation of calming and cognitive techniques in daily life and when facing anger-triggering situations; process the results, reinforcing success and problem-solving obstacles. EBT
14. EBT-Learn and implement thought-stopping as part of new approach to managing angry feelings when they arise. (25)	25. As part of a multicomponent coping strategy (e.g., "stop, calm, think, and act" approach), assign the client to implement a "thought-stopping" technique in which the client shouts STOP in his/her/their mind at the first signs of anger (or supplement with "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review implantation, reinforcing success and problem-solving obstacles. EBT
15. EBT-Learn and implement assertive communication skills for addressing frustration and anger in an honest, appropriate, respectful, and direct manner. (26)	26. Use skills-training interventions (e.g., instruction, modeling, role-playing, rehearsal, and practice) to help the client learn and implement assertive communication, highlighting its distinctive elements as well as the pros and cons of assertive, unassertive (passive), and aggressive communication (or supplement with *Your Perfect Right* by Alberti and Emmons). EBT
16. EBT-Learn and implement problem-solving/solution-finding skills and/or conflict resolution skills to address personal and interpersonal problems. (27, 28, 29)	27. Use skills-training interventions (e.g., instruction, modeling, role-playing, rehearsal, and practice) to help the client learn and implement problem-solving/solution-finding 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 (or supplement with "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT 28. Use skills-training interventions (e.g., instruction, modeling, role-playing, rehearsal, and practice) to help the client learn and implement conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, problem-solving, compromise. EBT 29. Conduct conjoint sessions to help the client implement new personal and interpersonal skills (e.g., assertion, problem-solving, and/or conflict resolution skills) with his/her/their significant other (or supplement with "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT
17. EBT-Practice using new anger management skills in session with the therapist and during homework exercises. (30, 31, 32)	30. 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/their needs. EBT 31. Select situations with the client in which the client will be increasingly challenged to apply new strategies for managing anger (i.e., graduated practice). EBT 32. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or in vivo exposure/behavioral experiments to help the client consolidate and generalize the use of new anger management skills. EBT
18. EBT-Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (33)	33. Monitor the client's reports of anger episodes toward the goal of decreasing their frequency, and increasing adaptive management through the client's use of new anger management skills (or supplement with "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma); review progress, reinforcing success and providing supportive corrective feedback toward sustained improvement. EBT
19. EBT-Verbalize an understanding of relapse prevention and the difference between a lapse and relapse. (34, 35)	34. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it. EBT 35. 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. EBT
20. EBT-Identify potential situations that could trigger a lapse and implement strategies to manage these situations. (36, 37, 38, 39)	36. Identify and rehearse with the client the management of future situations or circumstances in which lapses back to anger could occur. EBT 37. 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. EBT 38. 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. EBT 39. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains. EBT
21. Identify the advantages and disadvantages of holding on to anger and of forgiveness; discuss with therapist. (40, 41)	40. Discuss with the client forgiveness of the perpetrators of pain as a process of letting go of anger. 41. Assign the client to read *Forgive and Forget* by Smedes; process the content as to how it applies to the client's own life.
22. Write a letter of forgiveness to the perpetrator of past or present pain and process this letter with the therapist. (42)	42. 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.
23. Participate in acceptance and commitment therapy (ACT) for learning a new approach to anger and	43. Use an ACT approach to help the client experience and accept the presence of anger-invoking thoughts and images without allowing him/her/them to change the client's commitment to value-driven action; reinforce the client's efforts toward engaging in activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson). 44. Assign the client homework in which he/she/they practice lessons from ACT to consolidate the approach into

anger management. (43, 44, 45)

everyday life.

45. Assign the client reading consistent with the ACT approach to supplement work done in session (see *Get Out of Your Mind and into Your Life* by Hayes).

24. Learn and implement mindfulness meditation as part of a new approach to anger management and improved quality of life. (46)

46. Teach mindfulness meditation; help the client recognize the negative thought processes associated with anger and change his/her/their 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 Series] by Kabat‐Zinn)

25. Gain insight into the origins of current anger control problems by discussing experiences that may be involved in their development. (47)

47. Assist the client in identifying past relationship dynamics (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 the client handles anger.

26. Identify social supports that will help facilitate the implementation of anger management skills. (48)

48. Encourage the client to discuss anger management goals with trusted persons who are likely to support his/her/their change.

—. _____

—. _____

—. _____

—. _____

—. _____

—. _____

—. _____

—. _____

DIAGNOSTIC SUGGESTIONS

ICD‐10‐CM	***DSM‐5* Disorder, Condition, or Problem**
F63.81	Intermittent Explosive Disorder
F31.xx	Bipolar I Disorder
F31.81	Bipolar II Disorder
F91.x	Conduct Disorder
F07.0	Personality Change Due to Another Medical Condition
F43.10	Posttraumatic Stress Disorder
Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
Z69.82	Encounter for Mental Health Services for Perpetrator of Nonspousal Adult Abuse
F60.3	Borderline Personality Disorder
F60.2	Antisocial Personality Disorder
F60.0	Paranoid Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Unspecified Personality Disorder

Note

‐ 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 or 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 or 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.

—. _____

_____

—. _____

_____

—. _____

_____

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.

—. _____

_____

—. _____

_____

—. _____

_____

SHORT‐TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. EBP .Work cooperatively with the therapist toward agreed‐upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; validate the client's distress and difficulties as understandable given the particular circumstances; provide nonjudgmental support; and develop a level of trust with the client toward feeling safe to discuss his/her/their antisocial behavior and its impact on his/her/their life. EBP 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 and Lambert and *Vol. 2* by Norcross and Wampold). EBP
2. Admit to illegal and/or unethical behavior that has trampled on the law and/or the rights and feelings of others. (3, 4)	3. Explore the history of the client's pattern of illegal and/or unethical behavior and confront his/her/their attempts at minimization, denial, or projection of blame while showing how the client's own thinking pattern leads to illegal behavior (or supplement with “Crooked Thinking Leads to Crooked Behavior” or “Accept Responsibility for Illegal Behavior” from the *Adult Psychotherapy Homework Planner* by Jongsma). 4. Review the consequences for the client and others of the client's antisocial behavior (or supplement with “How I Have Hurt Others” from the *Adult Psychotherapy Homework Planner* by Jongsma).
3. Provide honest and complete information for a substance use history. (5)	5. 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. Provide behavioral, emotional, and attitudinal information toward an	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

assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)	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).
5. Explore and resolve ambivalence associated with commitment to change behaviors related to antisocial behavior pattern, including substance abuse if present. (10, 11, 12)	10. 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. 11. Ask open-ended questions to explore the client's own motivations for change, affirming the client's change-related statements and efforts (see *Substance Abuse Treatment and the Stages of Change* by Connors, Donovan, and DiClemente). 12. Elicit recognition of the discrepancy gap between current behavior and desired life goals, reflecting resistance without direct confrontation or argumentation.
6. Verbalize an understanding of the benefits for self and others of living within the laws and rules of society. (13, 14)	13. Teach the client that the basis for all relationships is trust that the other person will treat one with respect and kindness. 14. Teach the client the need for lawfulness as the basis for trust that forestalls anarchy in our society.
7. Make a commitment to live within the rules and laws of society. (15, 16)	15. Solicit a commitment from the client to conform to a prosocial, law-abiding lifestyle. 16. Emphasize the reality of negative consequences for the client if he/she/they continue to practice lawlessness.
8. List relationships that have been broken because of disrespect, disloyalty, aggression, or dishonesty. (17)	17. Review relationships that have been lost due to the client's antisocial attitudes and practices (e.g., disloyalty, dishonesty, aggression).
9. Acknowledge a pattern of self-centeredness in virtually all relationships. (18, 19)	18. Confront the client's lack of sensitivity to the needs and feelings of others. 19. Point out the self-focused, me-first, look-out-for-number-one attitude that is reflected in the client's antisocial behavior.
10. Make a commitment to be honest and reliable. (20, 21, 22)	20. Teach the client the value for self of honesty and reliability in all relationships because he/she/they benefit from social approval as well as increased trust and respect. 21. Teach the client the positive effect that honesty and reliability have for others, because he/she/they are not disappointed or hurt by lies and broken promises. 22. Ask the client to make a commitment to be honest and reliable.
11. Verbalize an understanding of the benefits to self and others of being empathetic and sensitive to the needs of others. (23, 24, 25)	23. Teach the client that the basis for all relationships is trust that the other person will treat one with respect and kindness. 24. Attempt to sensitize the client to his/her/their lack of empathy for others by revisiting the consequences of his/her/their behavior for others; use role reversal techniques. 25. Confront the client when he/she/they are rude or not being respectful of others and their boundaries.
12. List three actions that will be performed that will be acts of kindness and thoughtfulness toward others. (26)	26. Assist the client in listing three actions that he/she/they will perform as acts of service or kindness for others (or supplement with "Three Acts of Kindness" from the *Adult Psychotherapy Homework Planner* by Jongsma).
13. Indicate the steps that will be taken to make amends or restitution for hurt caused to others. (27, 28, 29)	27. Assist the client in identifying those who have been hurt by the client's antisocial behavior (or supplement with "How I Have Hurt Others" from the *Adult Psychotherapy Homework Planner* by Jongsma). 28. 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. 29. Encourage the client's commitment to specific steps that will be taken to apologize and make restitution to those who have suffered from the client's hurtful behaviors (or supplement with "Letter of Apology" from the *Adult Psychotherapy Homework Planner* by Jongsma).
14. Verbally demonstrate an understanding of the rules and duties related to employment. (30)	30. Review the rules and expectations that must govern the client's behavior in the work environment.
15. Attend work reliably and treat supervisors and coworkers with respect. (31, 32)	31. Monitor the client's attendance at work and reinforce reliability as well as respect for authority. 32. Ask the client to make a list of behaviors and attitudes that must be modified in order to decrease conflict with authorities; process the list.
16. Verbalize the obligations of parenthood that have been ignored. (33, 34)	33. Confront the client's avoidance of responsibilities toward his/her/their children. 34. Assist the client in listing the behaviors that are required to be a responsible, nurturing, and consistently reliable parent.

17. State a plan to meet responsibilities of parenthood. (35)

18. Increase statements of accepting responsibility for own behavior. (36, 37, 38)

19. Verbalize an understanding of how childhood experiences of pain have led to an imitative pattern of self-focused protection and aggression toward others. (39, 40)

20. Identify situations, thoughts, and feelings that trigger anger, angry verbal and/or aggressive behavioral actions. (41)

21. Complete psychological testing or objective questionnaires for assessing anger expression. (42)

22. Learn and implement calming and coping strategies as part of an overall approach to managing anger. (43, 44)

23. Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a less angry reaction. (45, 46)

24. Verbalize a list of constructive alternatives to aggressive anger in response to trigger situations. (47)

25. Verbalize a desire to forgive perpetrators of childhood abuse. (48)

26. Practice trusting a significant other with disclosure of personal feelings. (49, 50, 51)

35. Develop a plan with the client that will begin to implement the behaviors of a responsible parent.

36. Confront the client when he/she/they make blaming statements or fail to take responsibility for own actions, thoughts, or feelings (or supplement with "Accept Responsibility for Illegal Behavior" from the *Adult Psychotherapy Homework Planner* by Jongsma).

37. Explore the client's reasons for blaming others for his/her/their own actions (e.g., history of physically abusive punishment, parental modeling, fear of rejection, shame, low self-esteem, avoidance of facing consequences).

38. Give verbal positive feedback to the client when he/she/they take responsibility for his/her/their own behavior.

39. Explore the client's history of abuse, neglect, or abandonment in childhood (or supplement with "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.

40. 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.

41. As the client describes the history and nature of his/her/their anger issues in his/her/their 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 anger responses (consider supplementing with the exercise "Anger Journal" from the *Adult Psychotherapy Homework Planner* by Jongsma).

42. 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.

43. 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 angry feelings.

44. 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 daily life when facing anger trigger situations; process the results, reinforcing success and problem-solving obstacles.

45. Explore the client's self-talk that mediates angry feelings and actions (e.g., demanding expectations reflected in *should, must*, or *have*-to statements); identify and challenge biases, assisting the client 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.

46. Assign the client a homework exercise to identify angry self-talk and generate alternatives that help moderate angry reactions; review while reinforcing success, providing corrective feedback toward improvement.

47. 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 supplement with "Alternatives to Destructive Anger" from the *Adult Psychotherapy Homework Planner* by Jongsma).

48. 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.

49. Explore the client's fears associated with placing trust in others.

50. 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.

51. Process the experience of the client becoming vulnerable by self-disclosing to someone.

—. _____ —. _____

—. _____ —. _____

—. _____ —. _____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5* Disorder, Condition, or Problem**
F10.20	Alcohol Use Disorder, Moderate or Severe
F14.20	Cocaine Use Disorder, Moderate or Severe
F43.24	Adjustment Disorder, With Disturbance of Conduct
F91.x	Conduct Disorder

F63.81	Intermittent Explosive Disorder
F60.2	Antisocial Personality Disorder
F60.81	Narcissistic Personality Disorder

Note

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

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 two or more events or activities.
2. Excessive and/or unrealistic worry that is difficult to control and in response to a recent stressor(s).
3. Excessive and/or unrealistic worry.
4. Motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
5. Autonomic hyperactivity (e.g., palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, diarrhea).
6. Hypervigilance (e.g., feeling constantly on edge, experiencing concentration difficulties, having trouble falling or staying asleep, exhibiting a general state of irritability).

—. _____

—. _____

—. _____

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	THERAPEUTIC INTERVENTIONS
1. EBT Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	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 feeling safe to discuss generalized anxiety and its impact on his/her/their life. EBT 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 and Lambert and *Vol. 2* by Norcross and Wampold). EBT
2. Describe situations, thoughts, feelings, and actions associated with anxieties and worries, their impact on functioning, and attempts to resolve them. (3)	3. Ask the client to describe 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 anxiety symptoms (consider using a structured interview such as the *Anxiety and Related Disorders Interview Schedule for the DSM 5 by Brown and Barlow*).
3. Complete psychological tests designed to assess worry and anxiety symptoms. (4)	4. 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*; *Outcome Questionnaire OQ 45.2*; the *Symptom Checklist 90 R*).
4. Cooperate with and complete a medical evaluation. (5)	5. Arrange for a medical evaluation to rule out nonpsychiatric medical and substance-induced etiologies (e.g., hyperthyroidism, stimulant use).
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 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).

6. Cooperate with a medication evaluation by a prescriber. (10, 11)

10. Refer the client to a prescriber for a medication evaluation.
11. Monitor the client's medication adherence, side effects, and effectiveness; confer as indicated with the prescriber.

7. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment. (12, 13, 14)

12. Discuss how anxiety typically involves excessive worry about unrealistically appraised threats, various bodily expressions of overarousal, 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).
13. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduce overarousal, eliminate unnecessary avoidance, and reengage in rewarding activities.
14. Assign the client to read psychoeducational materials as a bibliotherapy adjunct to in-session work (e.g., *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow; *The Anxiety and Worry Workbook* by Clark and Beck).

8. Learn and implement calming skills to reduce overall anxiety and manage anxiety. (15, 16)

15. Teach the client calming/relaxation/mindfulness 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 daily life (see *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens; or supplement with *The Relaxation and Stress Reduction Workbook* by Davis et al.).
16. Assign the client homework in which he/she/they practice calming/relaxation/mindfulness skills daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success; resolve obstacles toward sustained implementation (or supplement with "Deep Breathing Exercise" in the *Adult Psychotherapy Homework Planner* by Jongsma).

9. 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 and teach a worry time intervention in which the client postpones interacting with worries until a designated time and place; use worry time for exposure (repeating worry toward extinction) and/or the application of problem-solving skills to address worries; agree upon and implement a worry time with the client.
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 supplement with "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; resolve obstacles toward sustained implementation.

10. Verbalize an understanding of the role that thinking plays in worry, anxiety, and avoidance. (19, 20, 21)

19. Discuss examples demonstrating how unproductive worry typically overestimates the probability of threats and underestimates or overlooks the client's ability to manage realistic demands (or supplement with "Past Successful Anxiety Coping" in the *Adult Psychotherapy Homework Planner* by Jongsma).
20. Assist the client in analyzing worries by examining potential biases such as the probability of the negative expectation occurring, the real consequences of it occurring, ability to control the outcome, the worst possible outcome, and ability to accept it (or supplement with "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 creates acute and/or chronic anxious apprehension, leading to avoidance that precludes finding solutions to problems.

11. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (22, 23)

22. Using techniques from cognitive behavioral therapies including intolerance of uncertainty and metacognitive therapies explore the client's self-talk, underlying assumptions, schema, or metacognition that mediate anxiety; assist the client in challenging and changing biases; conduct behavioral experiments to test biased versus unbiased predictions toward dispelling unproductive worry and increasing self-confidence in addressing the subject of worry (see *Cognitive Therapy of Anxiety Disorders* by Clark and Beck; *Metacognitive Therapy for Anxiety and Depression* by Wells).
23. Assign the client a homework exercise to identify fearful self-talk, identify biases in the self-talk, generate alternatives, and test them through behavioral experiments (or supplement with "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

12. Participate in gradual imaginal and/or live exposure to the feared negative consequences predicted by worries and develop alternative reality-based predictions. (24, 25, 26, 27, 28)

24. Direct and assist the client in constructing a hierarchy of feared worries (e.g., harm to others or self), of avoided activities (e.g., travel, medical), or both if needed.
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.
26. Conduct worry exposure by asking 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).
27. Conduct exposure in vivo to activities that the client avoids due to unrealistic worry, gradually targeting the removal of any unnecessary, anxiety-driven safety behaviors (see *Mastery of Your Anxiety and Worry: Therapist Guide* by Zinbarg, Craske, and Barlow).
28. Assign the client a homework exercise in which he/she/they do worry exposures and record responses (see *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow); review, reinforce success, and provide corrective feedback toward improvement.

13. Learn and implement problem-solving strategies for realistically addressing worries. (29, 30)

29. Teach the client problem-solving/solution-finding strategies to replace unproductive worry involving specifically defining a problem, generating options for addressing it, evaluating the pros and cons of each option, selecting and implementing an action plan, and reevaluating and refining the action (or supplement with "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).
30. Assign the client a homework exercise in which he/she/they solve a current problem (see *Mastery of Your Anxiety and Worry: Workbook* by Craske and Barlow); review, reinforce success, and resolve obstacles toward sustained

implementation. EBT

14. EBT Identify and engage in rewarding activities on a daily basis. (31)

31. 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 supplement with "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; problem-solve obstacles toward sustained implementation. EBT

15. EBT Learn and implement personal and interpersonal skills to reduce anxiety and improve interpersonal relationships. (32, 33)

32. Use instruction, modeling, and role-playing to build the client's general social, communication, and/or conflict resolution skills. EBT

33. Assign the client a homework exercise in which he/she/they implement social skills into daily life (or supplement with "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma); review, reinforce success, and problem-solve obstacles toward sustained implementation. EBT

16. Learn a nonjudgmental, accepting approach to worries, overcoming avoidance, and engaging in action toward personally meaningful goals. (34)

34. Use techniques from acceptance-based behavior therapies including psychoeducation about worry; mindfulness, cue detection, monitoring, and decentering; relaxation and mindfulness techniques; and mindful action toward expanding present-moment awareness; encourage acceptance rather than judgment and avoidance of internal experiences; and promote action in areas of importance to the individual (see "An Acceptance-based Behavioral Therapy for Generalized Anxiety Disorder" by Roemer and Orsillo; or supplement with *The Mindful Way Through Anxiety* by Orsillo and Roemer)

17. EBT Learn and implement relapse prevention strategies for preventing or managing possible setbacks. (35, 36, 37, 38, 39)

35. 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. EBT

36. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur (i.e., high-risk times). EBT

37. Instruct the client to continue using new and effective therapeutic skills (e.g., relaxation, cognitive restructuring, exposure, and problem-solving) in daily life to address emergent worries, anxiety, and avoidant tendencies. EBT

38. Develop a "coping card" or other reminder on which new and effective worry management skills and other important information (e.g., "Breathe deeply and relax," "Challenge unrealistic worries," "Use problem-solving") are available to the client for later use. EBT

39. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains. EBT

18. EBT Discuss ambivalence about changing current worry patterns toward deciding on whether to make changes. (40)

40. Use motivational interviewing techniques to assess the client's current stage of change and willingness to take action steps toward change (see *Motivational Interviewing* by Miller and Rollnick). EBT

19. Utilize a paradoxical intervention technique to reduce the anxiety response. (41)

41. 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.

20. Complete a cost-benefit analysis of maintaining the anxiety. (42)

42. 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 the client lists the advantages and disadvantages of the negative thought, fear, or anxiety; process the completed assignment.

21. Identify the major life conflicts from the past and present that form the basis for present anxiety. (43, 44, 45)

43. Assist the client in becoming aware of key unresolved life conflicts and in starting to work toward their resolution.

44. Reinforce the client's insights into the role of past emotional pain and present anxiety.

45. Ask the client to develop and process a list of key past and present life conflicts that continue to cause worry.

22. Maintain involvement in work, family, and social activities. (46)

46. Support the client in following through with work, family, and social activities rather than escaping or avoiding them to focus on anxiety.

23. Reestablish a consistent sleep-wake cycle. (47)

47. Teach and implement sleep hygiene practices to help the client reestablish a consistent sleep-wake cycle; review, reinforce success, and problem-solve obstacles toward sustained implementation.

—. _____ —. _____

_____ _____

—. _____ —. _____

_____ _____

—. _____ —. _____

_____ _____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5*** **Disorder, Condition, or Problem**
F41.1	Generalized Anxiety Disorder
F41.8	Other Specified Anxiety Disorder

F41.9 Unspecified Anxiety Disorder

F43.22 Adjustment Disorder, With Anxiety

Note

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

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)—ADULT

BEHAVIORAL DEFINITIONS

1. Childhood history of attention deficit hyperactivity disorder (ADHD)—primarily inattentive/primarily hyperactive/combined that was diagnosed during childhood or based on a history of symptoms meeting criteria.
2. Often fails to give close attention to detail or makes mistakes.
3. Often fidgets with or taps hands and feet or squirms in seat.
4. Often has difficulty sustaining attention in tasks or activities.
5. Often does not seem to listen when spoken to directly.
6. Often feels restless.
7. Often does not follow through on instructions and fails to finish duties.
8. Often unable to engage in leisure activities quietly.
9. Often has difficulty organizing tasks and activities.
10. Is often "on the go," acting as if "driven by a motor."
11. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.
12. Often talks excessively.
13. Often loses things necessary for tasks or activities.
14. Often interrupts, doesn't wait for his/her/their turn, or blurts out answers before a question has been completed.
15. Is easily distracted by extraneous stimuli.
16. Is often forgetful in daily activities.

—. _____

—. _____

_____

—. _____

_____

LONG-TERM GOALS

1. Sufficiently reduce inattentive/hyperactive/combined symptoms to function effectively in daily life.
2. Reduce impulsive actions while increasing concentration and focus on activities.
3. Minimize ADHD behavioral interference in daily life.
4. Accept ADHD as a chronic issue and need for continuing medication treatment.
5. Sustain attention and concentration for consistently longer periods of time.
6. Achieve a satisfactory level of balance, structure, and intimacy in personal life.

—. _____

—. _____

_____

—. _____

_____

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. Describe past and present experiences with ADHD including its effects on functioning. (3)
2. Cooperate with and complete psychological testing. (4)
3. Cooperate with and complete a medical evaluation. (5)
4. Comply with all recommendations based on the medical and/or psychological evaluations. (6, 7)

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 feeling safe to express ADHD vulnerabilities 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 progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross and Lambert and *Vol. 2* by Norcross and Wampold).
3. Conduct a thorough psychosocial assessment including past and present symptoms of ADHD and their effects on educational, occupational, and social functioning.
4. Conduct or arrange for psychological testing to further assess ADHD, other possible psychopathology (e.g., anxiety, depression), and relevant rule-outs (e.g., ADHD, conduct/antisocial features); provide feedback on testing results.
5. Arrange for a medical evaluation to rule out nonpsychiatric medical and substance-induced etiologies (e.g., hypo/hyperthyroidism, stimulant use, thyroid replacement meds).
6. Process the results of the medical evaluation and/or psychological testing with the client and answer any questions that may arise.
7. Conduct a conjoint session with significant others and the client to present the results of the psychological and medical evaluations; answer any questions he/she/they may have and solicit his/her/their support in dealing with the client's condition.

5. .Participate in a medication evaluation and take medication as prescribed, if prescribed. (8, 9)

6. Disclose any history of substance use that may contribute to and complicate the treatment of ADHD. (10)

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. (11, 12, 13, 14)

8. Identify the current specific ADHD behaviors that cause the most difficulty. (15, 16, 17)

9. List the negative consequences of the ADHD problematic behavior. (18)

10. .Invite a significant other to join in the therapy to provide support throughout therapy. (19)

11. Significant other learns the HOPE technique to help support the client's positive changes. (20)

12. .Increase knowledge of ADHD and its treatment. (21, 22, 23)

13. Read self-help books about ADHD to improve understanding of the condition and its features. (24)

14. .Learn and implement organization and planning skills. (25, 26, 27, 28)

8. Refer for a medication evaluation; if ambivalent, use motivational interviewing techniques to help the client explore pros and cons toward agreement to adhere to the prescription, if prescribed (or supplement with "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma).
9. Monitor the client's psychotropic medication adherence, side effects, and effectiveness; confer as indicated with the prescriber.
10. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substances Use chapter in this *Planner*).
11. 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).
12. 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).
13. 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.
14. 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).
15. Assist the client in identifying the current specific behaviors that cause him/her/them the most difficulty functioning as part of identifying treatment targets (i.e., a functional analysis).
16. Review the results of psychological testing and/or psychiatric evaluation again with the client assisting in identifying or in affirming his/her/their choice of the most problematic behavior(s) to address.
17. Ask the client to have extended family members and close collaterals complete a ranking of the behaviors he/she/they see as interfering the most with daily functioning (e.g., mood swings, temper outbursts, easily stressed, short attention span, never completes projects).
18. Assign the client to make a list of negative consequences that he/she/have experienced or that could result from a continuation of the problematic behavior; process the list (or supplement with "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).
19. 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.
20. 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).
21. 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.
22. 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.).
23. Assign the client readings consistent with the treatment model to increase knowledge of ADHD and its treatment (e.g., *Mastering Your Adult ADHD: Client Workbook* by Safren et al; *The New Attention Deficit Disorder in Adults Workbook* by Weiss).
24. Assign the client self-help readings that help facilitate the client's understanding of ADHD (e.g., *Delivered from 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.
25. Teach the client organization and planning skills including the routine use of a calendar and daily task list.
26. Develop with the client a procedure for classifying and managing mail and other papers.
27. 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.
28. Assign homework asking the client to apply problem-solving skills to an everyday problem (i.e., impulse control, angry outbursts, mood swings, staying on task, attentiveness); review and provide corrective feedback toward improving the skill (or supplement with e.g., "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma).
29. 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 he/she/they report distraction; use this as an approximate measure of his/her/their typical attention span. EBT

15. EBT Learn and implement skill to reduce the disruptive influence of distractibility. (29, 30, 31, 32)

30. Teach the client to break down tasks into meaningful smaller units that can be completed within the limits of his/her/their demonstrated attention span. EBT
31. Teach the client to use timers or other cues to remind him/her/them to stop tasks before he/she/they get distracted in an effort to reduce the time he/she/they may be distracted and off task (see *Mastering Your Adult ADHD: Therapist Guide* by Safren et al.). EBT
32. 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 or herself for successful focus and follow-through. EBT

16. EBT Identify, challenge, and change self-talk that contributes to maladaptive feelings and actions. (33, 34, 35)

33. 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, generate alternatives, and do behavioral experiments to reinforce the validity of the alternatives (see *Cognitive Behavior Therapy* by Beck). EBT
34. Use a metacognitive therapy approach that examines the client's "thinking about his/her/their thinking" (i.e., the meaning the client places on vulnerabilities associated with ADHD and his/her/their thoughts about how to respond to them accordingly) toward developing a more adaptive plan based on a new, less threatening metacognitive appraisals (see *Metacognitive Therapy for Anxiety and Depression* by Wells).
35. Assign homework asking client to use new cognitive appraisals while doing tasks in which maladaptive thinking has occurred previously; review, reinforce successes, problem-solve obstacles toward sustained improvement using the skills. EBT

17. EBT Acknowledge procrastination and the need to reduce it. (36)

36. Assist the client in identifying positives and negatives of procrastinating toward the goal of engaging the client in staying focused. EBT

18. EBT Learn and implement skills to reduce procrastination. (37, 38, 39)

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. EBT
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. EBT
39. Assign homework asking the client to accomplish identified tasks without procrastination using the techniques learned in therapy (or supplement with "Self-Monitoring/Self-Reward Program" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and provide corrective feedback toward improving the skill and decreasing procrastination. EBT

19. EBT Combine skills learned in therapy into a new daily approach to managing ADHD. (40, 41, 42)

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. EBT
41. Select situations in which the client will be increasingly challenged to apply new strategies for managing ADHD, starting with situations highly likely to be successful. EBT
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 new ADHD management skills. EBT

20. EBT 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 the client to use them daily or when stress increases (recommend *The Relaxation and Stress Reduction Workbook* by Davis et al.; or supplement with "Deep Breathing Exercise" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT

21. List coping skills that will be used to manage ADHD symptoms. (44)

44. Review with the client the symptoms that have been problematic and the newly learned coping skills the client will use to manage the symptoms (or supplement with "Symptoms and Fixes for ADD" in the *Adult Psychotherapy Homework Planner* by Jongsma).

22. Learn and practice mindful meditation to enhance attentional focus. (45)

45. Explain the rationale and teach the client mindful meditation to enhance attention regulation; apply the skill in other tasks requiring attentional focus within the client's limitations.

23. Attend an ADHD support group with or without significant other. (46)

46. Refer the client to a specific group therapy for adults with ADHD to increase the client's understanding of ADHD, to boost self-esteem, and to obtain feedback from others; encourage inclusion of significant other.

24. Report improved listening skills without defensiveness. (47)

47. Use role-playing and modeling to teach the client how to listen and accept feedback from others regarding the client's behavior.

—. _____ —. _____

—. _____ —. _____

—. _____ —. _____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5* Disorder, Condition, or Problem**
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder
F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder
F31.xx	Bipolar I Disorder
F34.0	Cyclothymic Disorder
F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
F10.20	Alcohol Use Disorder, Moderate or Severe
F10.10	Alcohol Use Disorder, Mild
F12.20	Cannabis Use Disorder, Moderate or Severe
F12.10	Cannabis Use Disorder, Mild
_____	_____
_____	_____

Note

- 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.

16. _____
17. _____
18. _____

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 of depression and help prevent its relapse.
3. Develop healthy interpersonal relationships that lead to the alleviation of depression and help prevent its relapse.
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. Optimize sleep and activity patterns that lead to alleviation of depression and help prevent its relapse.
8. Build self-esteem or reduce guilt, fears of rejection, dependency, or abandonment.

9. _____
10. _____
11. _____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. EB Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	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 feeling safe to discuss bipolar depression and its impact on his/her/their life. EB 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 progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross and Lambert and *Vol. 2* by Norcross and Wampold). EB
2. Participate in an evaluation of your present and past experiences with changes in mood, including their impact on functioning and quality of life. (3)	3. Assess presence, severity, and impact of past and present mood episodes on social, occupational, and interpersonal functioning; supplement with semistructured inventory, if desired (e.g., *Montgomery Asberg Depression Rating Scale*, *Inventory to Diagnose Depression*); readminister as indicated to assess treatment response.
3. Complete psychological testing to assess the nature and impact of mood problems. (4)	4. 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. Cooperate with and complete a medical evaluation. (5)	5. Arrange for a medical evaluation to rule out nonpsychiatric medical and substance-induced etiologies of the mood symptoms (e.g., thyroid dysregulation, sedative use).

5. Disclose any history of substance use that may contribute to mood vulnerabilities or complicate treatment. (6)	6. Arrange for an evaluation of substance use disorder(s) and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).
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. (7, 8, 9, 10)	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 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). 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 imsspairment 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. Verbalize any history of past and present suicidal thoughts and actions. (11)	11. 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).
8. State no longer having thoughts of self-harm. (12, 13)	12. Continuously assess and monitor the client's suicide risk. 13. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her/their own basic needs, or symptom severity warrants it.
9. EB V Cooperate with a medication evaluation for medication needs to stabilize symptoms. (14)	14. Arrange for a medication evaluation with a prescriber to determine appropriate pharmacotherapy (e.g., Depakote, Lamictal, Latuda). EB V
10. EB V Take prescribed medications as directed. (15) 11. EB V Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (16)	15. Monitor the client for psychotropic medication prescription adherence, side effects, and effectiveness; consult with prescriber as indicated. EB V 16. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in individual or group therapy. EB V
12. EB V Verbalize an understanding of the causes for, symptoms of, and treatment of depressive episodes within bipolar disorder. (17, 18)	17. 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 (see *Clinician's Guide to Bipolar Disorder* by Miklowitz and Gitlin). EB V 18. 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 adherence. EB V
13. EB V Verbalize an understanding of the rationale for treatment. (19).	19. 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 V
14. EB V Verbalize acceptance of the need to take psychotropic medication and commit to prescription adherence including possible blood-level monitoring. (20, 21)	20. Educate the client about the importance of medication adherence; teach the client the risk for relapse if medication is discontinued and work toward a commitment to prescription adherence. EB V 21. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription nonadherence; develop a plan for recognizing and addressing them (or supplement with "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB V
15. EB V Attend group sessions designed to inform members of the nature, causes, and treatment of bipolar disorder, as well as skills for managing it. (22, 23)	22. Conduct or refer the client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in development and maintenance of bipolar disorder, as well as its biological and psychological treatment (see *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta). EB V 23. 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, adherence to medication, and ways to minimize relapse through stress management (or supplement with "Early Warning Signs of Depression" and "Identifying and Handling Triggers" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB V
16. EB V Client and family members verbalize an understanding of bipolar disorder, factors that influence it, and the important role of medication and therapy. (24)	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: A Family Focused Treatment Approach* by Miklowitz and Goldstein). EB V

17. .Family members implement skills that help manage the client's bipolar disorder, prevent relapse, and improve the quality of life of the family and its members. (25, 26, 27, 28, 29)

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.
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 while reducing negative expressed emotion.
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 options, 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, process results in session toward effective use, problem-solve obstacles (or supplement with "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma), process results in session.

18. .Develop a "relapse drill" in which roles, responsibilities, and a course of action are agreed upon in the event that signs of relapse emerge. (30)

30. 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.

19. .Identify and replace thoughts and behaviors that may trigger manic or depressive symptoms. (31, 32, 33)

31. Use cognitive therapy techniques to assess, challenge, and change cognitive biases that contribute to depression (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.).
32. Assign the client behavioral experiments as homework exercises in which he/she/they test cognitive biases against alternatives toward eventual adoption of the alternatives in appraising self, others, and the environment (or supplement with "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success and problem-solving obstacles toward sustained implementation.
33. 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.).

20. Maintain a pattern of regular rhythm to daily activities. (34, 35, 36, 37)

34. 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).
35. Assist the client in establishing an optimal social rhythm involving a routine pattern of balanced 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 rewarding, predictable rhythm every day (or supplement with "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma).
36. Help the client establish a good sleep cycle as part of his/her/their social rhythm, teaching good sleep hygiene practices (see "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly until implemented reliably (see the Sleep Disturbance chapter in this *Planner*).
37. Engage the client in a balanced schedule of "behavioral activation" by scheduling rewarding activities while not overstimulating (or supplement with "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.

21. Discuss and resolve troubling personal and interpersonal issues. (38, 39, 40)

38. Conduct the interpersonal component of interpersonal and social rhythm therapy beginning with the assessment the client's "Interpersonal Inventory" of current and past significant relationships; assess for themes related to unresolved grief, interpersonal disputes, role transitions, and interpersonal isolation (see *Treating Bipolar Disorder* by Frank; *The Guide to Interpersonal Psychotherapy* by Weissman et al.).
39. Use interpersonal therapy techniques to explore and resolve issues surrounding grief, role disputes, role transitions, isolation, and social skills deficits; provide support and strategies for resolving identified interpersonal issues.
40. 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 (or supplement with "Keeping a Daily Rhythm" in the *Adult Psychotherapy Homework Planner* by Jongsma).

22. Participate in periodic "maintenance therapy" sessions. (41)

41. Hold periodic "maintenance" sessions within the first few months after therapy to facilitate the client's positive changes; reinforce successes and problem-solve obstacles toward sustained stability.

23. Increase understanding of bipolar disorder by reading a recommended book on the disorder. (42)

42. 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 and Goldstein, *The Bipolar Disorder Workbook* by Forester and Gregory, *Bipolar 101* by White and Preston); review and process concepts learned through the reading.

24. Differentiate between real and imagined losses, rejections, and abandonments. (43, 44, 45)

43. Pledge to be there consistently to help, listen to, and support the client.
44. Explore the client's fears of abandonment by sources of love and nurturance.
45. Help the client differentiate between real and imagined, actual and exaggerated losses.

25. Verbalize grief, fear, and anger regarding real or imagined losses in life. (46, 47, 48)

46. Probe real or perceived losses in the client's life.
47. Review ways for the client to replace the losses and put them in perspective.
48. Probe the causes for the client's low self-esteem and abandonment fears in the family-of-origin history.

26. Increase value-based actions in daily life while learning how to manage thoughts and feelings that would stop or decrease these actions. (49)

27. Increasingly verbalize hopeful and positive statements regarding self, others, and the future. (50, 51)

49. Conduct acceptance and commitment therapy (see *ACT for Depression* by Zettle) to help the client decrease experiential avoidance, disconnect thoughts from actions, accept one's experience rather trying to suppress or control unwanted thoughts and feelings, and behave according to his/her/their broader life values; assist the client in clarifying goals and values and committing to behaving accordingly; add mindfulness strategies to strengthen present-focused experiencing.

50. Assign the client to write at least one positive affirmation statement daily regarding himself/herself/themselves and the future (or supplement with "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

51. Teach the client more about depression and how to recognize and accept some sadness as a normal variation in feeling.

—. _____

—. _____

—. _____

—. _____

—. _____

—. _____

—. _____

—. _____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5* Disorder, Condition, or Problem**
F31.1x	Bipolar I Disorder, Manic
F31.81	Bipolar II Disorder
F34.0	Cyclothymic Disorder
F25.1	Schizoaffective Disorder, Depressive Type
F31.9	Unspecified Bipolar and Related Disorder
F07.0	Personality Change Due to Another Medical Condition

Note

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

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, due to distractibility and impairment in discipline and goal-directedness.

—. _____

—. _____

—. _____

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 and gain insight and strength in addressing guilt, fears of rejection, dependency, and abandonment that foster feelings of low self-worth.

—. _____

—. _____

—. _____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. EB .Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	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 feeling safe to discuss bipolar disorder and its impact on his/her/their life. EB 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 and Lambert and *Vol. 2* by Norcross and Wampold). EB
2. Describe mood state, energy level, amount of control over thoughts, and sleeping pattern. (3)	3. 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; or supplement with semistructured inventory (e.g., *Young Mania Rating Scale;* the *Clinical Monitoring Form*); readminister as indicated to assess treatment response.
3. Complete psychological testing to assess the nature and impact of mood problems. (4)	4. 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. Cooperate with and complete a medical evaluation. (5)	5. Arrange for a medical evaluation to rule out nonpsychiatric medical and substance-induced etiologies of the mood symptoms (e.g., thyroid dysregulation, stimulant use).
5. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar disorder. (6)	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*).

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. (7, 8, 9, 10)

7. Verbalize any history of past and present suicidal thoughts and actions. (11)

8. State no longer having thoughts of self-harm. (12, 13)

9. EB .Cooperate with a medication evaluation to reduce symptoms and stabilize mood. (14)

10. EB .Take prescribed medications as directed. (15, 16)

11. EB .Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (17)

12. EB .Verbalize an understanding of the causes for, symptoms of, and treatment of manic or hypomanic episodes. (18, 19, 20)

13. EB .Verbalize acceptance of the need to take psychotropic medication and commit to prescription adherence with possible blood level monitoring. (21, 22)

14. EB .Attend group psychoeducational sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (23, 24)

15. EB .Identify and replace thoughts and behaviors that may trigger manic or depressive symptoms. (25, 26, 27)

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 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).
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 history of suicidality and current state of suicide risk (see the Suicidal Ideation chapter in this *Planner* if suicide risk is present).
12. Continuously assess and monitor the client's suicide risk.
13. Arrange for or continue hospitalization if the client is assessed to be potentially harmful to self or others, unable to care for his/her/their own basic needs, or symptom severity warrants it.
14. Arrange for a medication evaluation with a prescriber to determine appropriate pharmacotherapy (e.g., Depakote, Lamictal, Latuda). EB
15. Connect the client with an outpatient systematic care team to manage medications and provide support services (see *Structured Group Psychotherapy for Bipolar Disorder* by Bauer and McBride. EB
16. Monitor the client for use and effectiveness of psychotropic medication adherence, side effects, and effectiveness; consult with prescriber as indicated). EB
17. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in individual or group psychotherapy. EB
18. 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
19. 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 require medication adherence to prevent relapse. EB
20. 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
21. Educate the client about the importance of medication adherence; teach the client the risk for relapse when medication is discontinued, and work toward a commitment to prescription adherence. EB
22. Assess risk factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription nonadherence; develop a plan for recognizing and addressing them (or supplement with "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB
23. Conduct or refer 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 *Structured Group Psychotherapy for Bipolar Disorder* by Bauer and McBride; *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta). EB
24. 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 adhere to one's medication prescription, and ways to minimize relapse through stress management (or supplement with "Identifying and Handling Triggers" or "Recognizing the Negative Consequences of Impulsive Behavior" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB
25. Use cognitive therapy techniques to identify, challenge, and change cognitive appraisals that make the client vulnerable to manic or depressive episodes (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.).
26. Assign the client homework exercises in which he/she/they do behavioral experiments to test biased versus alternative predictions (or supplement with "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review using guided discovery and reinforce gains toward sustained improvement.
27. 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.).

16. Client and family members verbalize an understanding of bipolar disorder, factors that influence it, and the role of medication and therapy in its management. (28, 29)	28. 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: A Family Focused Treatment Approach* by Miklowitz and Goldstein). 29. 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.
17. Family members implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (30, 31, 32)	30. 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. 31. 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. 32. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills (or supplement with "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; reinforce gains; problem-solve obstacles toward sustained, effective use.
18. Develop a "relapse drill" in which roles, responsibilities, and a course of action are agreed upon in the event that signs of relapse emerge. (33)	33. Help the client and family create 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.
19. Maintain a pattern of regular rhythm to daily activities. (34, 35, 36, 37)	34. 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). 35. Assist the client in establishing a 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 (or supplement with "Keeping a Daily Rhythm" in the *Adult Psychotherapy Homework Planner* by Jongsma). 36. Teach the client sleep hygiene practices (or supplement with "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly toward sustained, effective use (see the Sleep Disturbance chapter in this *Planner*). 37. Engage the client in a balanced schedule of "behavioral activation" by scheduling rewarding activities while not overstimulating (or supplement with "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 gains, problem-solve obstacles toward sustained implementation.
20. Discuss and resolve troubling personal and interpersonal issues. (38, 39, 40)	38. 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 (see *Treating Bipolar Disorder* by Frank; *The Guide to Interpersonal Psychotherapy* by Weissman et al.). 39. 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. 40. 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, as needed.
21. Participate in periodic "maintenance" sessions. (41)	41. Hold periodic "maintenance" sessions within the first few months after therapy to facilitate the client's positive changes; problem-solve obstacles to maintain improvement and prevent relapse.
22. Increase understanding of bipolar disorder by reading or viewing information on the disorder and its management. (42)	42. Ask the client to read or view material (e.g., online) on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder Survival Guide* by Miklowitz; *The Bipolar Disorder Workbook* by Forester and Gregory; *Bipolar 101* by White and Preston); review and process concepts learned through the reading.
23. Differentiate between real and imagined losses, rejections, and abandonments. (43, 44, 45)	43. Pledge to be there consistently to help, listen to, and support the client. 44. Explore the client's fears of abandonment by sources of love and nurturance. 45. Help the client differentiate between real and imagined, actual and exaggerated losses.
24. Verbalize grief, fear, and anger regarding real or imagined losses in life. (46, 47)	46. Probe real or perceived losses in the client's life. 47. Review ways for the client to place the losses in perspective.
25. Acknowledge the low self-esteem and fear of rejection that underlie the braggadocio. (48, 49)	48. Probe the causes for the client's low self-esteem and abandonment fears in the family-of-origin history. 49. Confront the client's grandiosity and demandingness gradually but firmly; emphasize the client's good qualities (or supplement with "What Are My Good Qualities?" or "Acknowledging My Strengths" in the *Adult Psychotherapy Homework Planner* by Jongsma).
—. _____	—. _____
—. _____	—. _____

—. _____ —. _____

_____ _____

_____ _____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5* Disorder, Condition, or Problem**
F31.1x	Bipolar I Disorder, Manic
F31.81	Bipolar II Disorder
F34.0	Cyclothymic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F31.9	Unspecified Bipolar and Related Disorder
F07.0	Personality Change Due to Another Medical Condition

Note

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

BORDERLINE PERSONALITY DISORDER[1]

BEHAVIORAL DEFINITIONS

1. A pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity, beginning in early adulthood and present in a variety of contexts.
2. Frantic efforts to avoid real or imagined abandonment.
3. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
4. Identity disturbance: markedly and persistently unstable self-image or sense of self.
5. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
6. Recurrent suicidal behavior, gestures, or threats or self-mutilating behavior.
7. Affective instability due to marked mood reactivity (e.g., intense episodic dysphoria, irritability, or anxiety lasting a few hours and more rarely a few days).
8. Chronic feelings of emptiness.
9. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
10. Transient, stress-related paranoid ideation or severe dissociative symptoms.
11. Easily feels unfairly treated and believes that others cannot be trusted.
12. Appraises situations in dichotomous terms (e.g., right/wrong, black/white, trustworthy/deceitful) without adapting for extenuating circumstances or complex situations.
13. Has a history of childhood trauma.

—. _____

—. _____

—. _____

LONG-TERM GOALS

1. Develop and demonstrate skills to regulate emotional intensity and overreactivity, including anger management skills.
2. Develop the ability to control impulsive behavior.
3. Replace dichotomous thinking with the ability to tolerate ambiguity and complexity in relationships and situations.
4. Learn and implement effective interpersonal skills and appropriately assertive communication strategies
5. Replace self-damaging behaviors (such as substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors) with effective crisis management skills.
6. Develop a stable sense of self through acquisition of values-based behaviors to create a life worth living.

—. _____

—. _____

—. _____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. EBP-Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; validate the client's distress and difficulties as understandable given the client's particular circumstances; provide nonjudgmental support; and develop a level of trust with the client toward feeling safe to discuss borderline personality disorder and its impact on his/her/their life. EBP 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 and Lambert and *Vol. 2* by Norcross and Wampold). EBP
2. Discuss openly the history of cognitive, emotional, and behavioral difficulties that have led to seeking treatment. (3, 4)	3. Assess the client's experiences of distress and disability, identifying behaviors (e.g., self-harm, angry outbursts, apparent competence, active passivity), emotion dysregulation (e.g., mood swings, sensitivity, painful emptiness), and cognitions (e.g., biases such as dichotomous thinking, overgeneralization, catastrophizing) that will become the targets of therapy. 4. Explore the client's history of abuse, abandonment, and/or invalidation (i.e., experiences contributing to the development of discomfort and distrust of self and emotions).
3. Address any history of substance use that may contribute to and/or complicate the treatment of borderline personality. (5, 6)	5. Assess substance use and whether less severe substance use behaviors can be treated as self-harm and/or impulsive behaviors in the context of treatment for borderline personality disorder or if a separate substance use treatment is warranted. 6. If indicated, 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*).
4. Provide behavioral, emotional, and attitudinal information toward an	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 attention deficit hyperactivity disorder (ADHD), depression secondary to an anxiety disorder) including

assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

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. EBT Cooperate with a medication evaluation by a prescriber and take medication, if prescribed. (11, 12, 13)

11. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors, mood stabilizers) and arrange for medication evaluation, if indicated. EBT
12. Monitor and evaluate the effectiveness, side effects, and the client's adherence to the medication; facilitate the client's communication or consult with prescriber, as needed. EBT
13. Coordinate care with medication prescriber to reduce risk of misuse and lethality. EBT

6. EBT Verbalize a working understanding of dialectical behavior therapy (DBT), its structure, process, and therapeutic goals including the biosocial theory of the development of borderline personality disorder. (14, 15, 16)

14. Orient the client to DBT, highlighting its multiple facets (e.g., support, collaboration, and mindfulness, distress tolerance, coping, and interpersonal skills building); its use of exchange and negotiation, balancing of the rational and emotional mind, acceptance and change strategies (see *Dialectical Behavior Therapy in Clinical Practice* by Dimeff and Koerner; *DBT Skills Training Manual* by Linehan). EBT
15. Teach and collaboratively communicate to the client the dialectical/biosocial view of borderline personality, including biological and environmental vulnerabilities to the client. EBT
16. Throughout therapy, ask the client to read selected materials that reinforce therapeutic interventions (e.g., *DBT Skills Training Handouts and Worksheets* by Linehan or *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley). EBT

7. EBT Commit to work collaboratively with the therapist toward agreed upon therapeutic goals and to resist acting on life threatening, self harm urges. (17)

17. Using commitment strategies and motivational interviewing, 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, reducing self harm and suicidal behaviors, and participating in skills training to address the behavioral, emotional, and cognitive vulnerabilities targeted in treatment. EBT

18. Gather a thorough history of the client's self harm and suicidal behaviors. EBT
19. Assess suicidal thoughts and actions for onset, frequency, triggers, seriousness/risk, means, access to means, intent, and immediate consequences that may reward or maintain the self harm behaviors (i.e., their function). EBT

8. EBT Verbalize any history of self harm and suicidal urges and behavior. (18, 19, 20, 21, 22)

20. Arrange for hospitalization, as necessary, when the client is determined to be at high risk of life threatening self harm. EBT
21. Assign self monitoring forms (e.g., DBT Diary Cards) to be reviewed weekly at the start of each session to quickly assess self harm risk and determine if further assessment is required (recognizing that some level of suicidal ideation and urges may be chronically present and need not be assessed or discussed at every session). EBT
22. Provide the client with an emergency helpline telephone number that is available 24 hours a day. EBT

9. EBT Agree to initiate contact with the therapist or helpline if experiencing a strong urge to engage in self harmful behavior. (23, 24)

23. Provide the client with therapist's telephone number for phone coaching of skills learned in therapy to promote use in other settings; provide clear instructions of proper use of the phone including establishing limits (e.g., availability, reasonable wait time for return call, etc.). EBT
24. Elicit an agreement from the client that he/she/they will initiate contact with the therapist if self harm or suicidal urges become strong and *before* any self injurious behavior occurs (or supplement with the "No Self Harm Contract" in the *Adult Psychotherapy Homework Planner* by Jongsma); consistently assess the client's suicidal risk throughout therapy and intervene accordingly. EBT

10. EBT Reduce life threatening and self harm behaviors. (25, 26)

25. Teach the client how to apply DBT distress tolerance skills and chain analysis to identify and intervene to reduce self harm and suicidal behaviors. EBT
26. Assign self monitoring homework (e.g., DBT Diary Card) to help guide in session chain analyses and problem solving. EBT

11. EBT Reduce actions that interfere with participating in therapy. (27)

27. Continuously monitor, confront, and problem solve client actions that interfere with participation in therapy such as missing appointments, arriving late, nonadherence, and/or abruptly leaving therapy. EBT

12. EBT Reduce the frequency of maladaptive behaviors, thoughts, and feelings that interfere with attaining a reasonable quality of life. (28)

28. Use validation, dialectical (e.g., metaphor, devil's advocate), and cognitive behavioral strategies (e.g., cost benefit analysis, chain analysis, problem solving) to help the client manage, reduce, or regulate maladaptive behaviors, cognitive biases, and feelings (see *Dialectical Behavior Therapy in Clinical Practice* by Dimeff and Koerner; or supplement with "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT

13. EBT Participate in a group (preferably) or individual skills training course. (29, 30)

29. Conduct group or individual skills training tailored to the client's personal vulnerabilities and skill deficits including analyzing one's behavior, mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills (see *DBT Skills Training Manual* by Linehan. For individual skills training, see *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley). EBT
30. Use behavioral strategies to teach identified skills (e.g., instruction, modeling, advising), strengthen them (e.g., role playing with feedback and reinforcement), and facilitate incorporation into the client's everyday life (e.g., homework assignments). EBT

14. .Discuss previous or current posttraumatic stress. (31)

15. .Identify, challenge, and replace biased, fearful self.talk with reality.based, positive self.talk. (32, 33, 34)

16. .Participate in imaginal and/or in vivo exposure to trauma.related memories until talking or thinking about the trauma does not cause marked distress. (35, 36, 37, 38)

17. .Verbalize a sense of self. respect that is not dependent on others' opinions. (39)

18. .Engage in practices that help enhance a sustained sense of joy. (40)

19. .Learn and apply problem. solving skills to conflicts in daily life. (41)

20. Explore moment.to.moment interactions with the therapist to gain insight into self, others, and influences from one's developmental history. (42)

21. Explore and change self. defeating beliefs and behaviors resulting from previous relationships and experiences. (43)

22. Learn and implement mentalization skills to improve personal and interpersonal relatedness. (44)

31. After adaptive behavioral patterns and emotional regulation skills are evident, work with the client on posttraumatic sequelae, reducing avoidance or denial, increasing insight into its effects, reducing maladaptive emotional and/or behavioral responses to trauma.related stimuli, reducing self.blame, increasing acceptance and tolerance toward facilitating posttraumatic growth.

32. Explore the client's self.talk, underlying assumptions, and schema that mediate trauma.related and other fears; identify and challenge biases; assist the client in generating thoughts that correct for the negative biases, accept uncertainty, and build self.confidence.

33. Assign the client a homework exercise in which he/she/they identify fearful self.talk and create reality.based alternatives; review and reinforce success, problem.solve obstacles toward sustained improvement (or supplement with "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 et al.).

34. Reinforce the client's positive, reality.based cognitive messages that reduce personal distress, enhance self. confidence, and increase adaptive action.

35. Direct and assist the client in constructing a hierarchy of feared and avoided trauma.related stimuli.

36. Direct imaginal exposure by having the client describe a chosen traumatic experience at an increasing but client. chosen level of detail; integrate cognitive restructuring and repeat until new, adaptive learning is established; record the session and have the client listen to it between sessions (see *Dialectical Behavior Therapy in Clinical Practice* by Dimeff and Koerner (or supplement with "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma).

37. Assign the client a homework exercise in which he/she/they do an exposure exercise and record responses or listen to a recording of an in.session exposure (see *Dialectical Behavior Therapy in Clinical Practice* by Dimeff and Koerner); review and reinforce progress; problem.solve obstacles.

38. For client with active, comorbid posttraumatic stress disorder (PTSD), conduct prolonged exposure therapy or cognitive processing therapy (see the PTSD chapter in this *Planner*).

39. Help the client to clarify, value, believe, and trust in his/her/their self.evaluation and evaluations of 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.

40. Facilitate the client's personal and interpersonal growth and "capacity for sustained joy" by helping the client 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).

41. 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 supplement with "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma).

42. Conduct transference.focused therapy using client.therapist communications to help the client integrate split representations of self and develop more effective means to self.control (see *Psychotherapy for Borderline Personality* by Clarkin et al.).

43. Using cognitive, behavioral, and emotion.focused techniques, conduct schema.focused therapy to help clients learn and change entrenched, self.defeating patterns, focusing on the relationship with the therapist, daily life outside of therapy, and early developmental experiences including trauma (see *Schema Therapy* by Young, Klosko, and Weishaar).

44. Conduct mentalization therapy in which the client learns to interpret the actions of self and others through a meaningful and understanding examination of mental states such as personal desires, needs, feelings, beliefs, and reasons (see *Mentalization based Treatment for Borderline Personality Disorder* by Bateman and Fonagy.

20. Explore moment.to.moment interactions with the therapist to gain insight into self, others, and influences from one's developmental history. (42)

21. Explore and change self. defeating beliefs and behaviors resulting from previous relationships and experiences. (43)

22. Learn and implement mentalization skills to improve personal and interpersonal relatedness. (44)

42. Conduct transference.focused therapy using client.therapist communications to help the client integrate split representations of self and develop more effective means to self.control (see *Psychotherapy for Borderline Personality* by Clarkin et al.).

43. Using cognitive, behavioral, and emotion.focused techniques, conduct schema.focused therapy to help clients learn and change entrenched, self.defeating patterns, focusing on the relationship with the therapist, daily life outside of therapy, and early developmental experiences including trauma (see *Schema Therapy* by Young, Klosko, and Weishaar).

44. Conduct mentalization therapy in which the client learns to interpret the actions of self and others through a meaningful and understanding examination of mental states such as personal desires, needs, feelings, beliefs, and reasons (see *Mentalization based Treatment for Borderline Personality Disorder* by Bateman and Fonagy.

—. _____ —. _____

_____ _____

—. _____ —. _____

_____ _____

—. _____ —. _____

_____ _____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5* Disorder, Condition, or Problem**
F34.1	Persistent Depressive Disorder
F33.x	Major Depressive Disorder, Recurrent Episode
F60.3	Borderline Personality Disorder
F60.9	Unspecified Personality Disorder
F43.10	Posttraumatic Stress Disorder

Notes

[1] Dialectical Behavior Therapy content for this chapter was provided by Jean Clore, PhD, Department of Psychiatry and Behavioral Medicine, University of Illinois College of Medicine, Peoria.

. 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 (dissociative identity disorder, dissociative amnesia, and/or depersonalization/derealization) as a maladaptive coping mechanism resulting from childhood emotional pain.

—. _____

—. _____

—. _____

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	THERAPEUTIC INTERVENTIONS
1. EBT Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	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 feeling safe to express childhood trauma and its impact on his/her/their life. EBT 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 progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross and Lambert and *Vol. 2* by Norcross and Wampold). EBT
2. Describe what it was like to grow up in the home environment. (3)	3. Develop the client's family genogram and/or symptom line and help identify patterns of dysfunction within the family.
3. Acknowledge any dissociative phenomena that have resulted from childhood trauma. (4, 5)	4. Assist the client in understanding the role of dissociation in self-protecting from the pain of childhood abusive betrayals (see the Dissociation chapter in this *Planner*). 5. Assess the severity of the client's dissociation phenomena and hospitalize as necessary for his/her/their protection.
4. State the role substance abuse has in dealing with emotional pain of childhood. (6)	6. 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*).
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)	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 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). 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. Describe each family	

member and identify the role each played within the family. (11)	11. Assist the client in clarifying his/her/their role within the family and feelings connected to that role.
7. Identify patterns of abuse, neglect, or abandonment within the family of origin, both current and historical, nuclear, and extended. (12, 13)	12. Assign the client to ask parents about his/her/their family backgrounds and develop insight regarding patterns of behavior and causes for parents' dysfunction. 13. Explore the client's painful childhood experiences (or supplement with "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma).
8. Identify feelings associated with major traumatic incidents in childhood and with parental child-rearing patterns. (14, 15, 16)	14. Support and encourage the client when he/she/they begin to express feelings of rage, sadness, fear, and rejection relating to family abuse or neglect. 15. Assign the client to record feelings in a journal that describes memories, behavior, and emotions tied to traumatic childhood experiences (or assign "How the Trauma Affects Me" in the *Adult Psychotherapy Homework Planner* by Jongsma). 16. 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.
9. Identify how own parenting has been influenced by childhood experiences. (17)	17. Ask the client to compare his/her/their parenting behavior to that of parent figures of the client's childhood; encourage the client to be aware of how easily we repeat patterns that we grew up with.
10. Enroll in dialectical behavior therapy. (18)	18. 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*).
11. Enroll in treatment for posttraumatic stress. (19)	19. For the client who is manifesting posttraumatic stress disorder (PTSD), provide or refer to prolonged exposure therapy, cognitive processing therapy, or eye movement desensitization and reprocessing therapy (see the PTSD chapter in this *Planner*).
12. Implement relaxation techniques to counteract stress and anxiety surrounding the recall of childhood trauma. (20)	20. Train the client in deep muscle relaxation and deep breathing techniques to offset tension associated with recalling the trauma (or supplement with "Deep Breathing Exercise" from the *Adult Psychotherapy Homework Planner* by Jongsma).
13. Decrease feelings of shame by being able to verbally affirm self as not responsible for abuse. (21, 22, 23, 24)	21. Assign writing a letter to mother, father, or other abuser in which the client expresses feelings regarding the abuse. 22. Hold conjoint sessions where the client confronts the perpetrator of the abuse. 23. 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. 24. 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.
14. Identify the positive aspects for self of being able to forgive all those involved with the abuse. (25, 26, 27)	25. 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. 26. 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. 27. 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).
15. Decrease statements of being a victim while increasing statements that reflect personal empowerment. (28, 29)	28. 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.
16. Increase level of trust of others as shown by more socialization and greater intimacy tolerance. (30, 31)	29. 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). 30. 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). 31. Teach the client the advantages of treating people as trustworthy given a reasonable amount of time to assess their character.

—.	_____	—.	_____
	_____		_____
—.	_____	—.	_____
	_____		_____
—.	_____	—.	_____
	_____		_____

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	***DSM-5* Disorder, Condition, or Problem**
F34.1	Persistent Depressive Disorder

F32.x	Major Depressive Disorder, Single Episode
F33.x	Major Depressive Disorder, Recurrent Episode
F42	Obsessive.Compulsive Disorder
F41.1	Generalized Anxiety Disorder
F43.10	Posttraumatic Stress Disorder
F44.81	Dissociative Identity Disorder
F44.0	Dissociative Amnesia
F48.1	Depersonalization/Derealization Disorder
T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter

Note

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

CHRONIC PAIN

BEHAVIORAL DEFINITIONS

1. Experiences pain beyond the normal healing process (6 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.”

—. _____

—. _____

—. _____

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	THERAPEUTIC INTERVENTIONS
1. EBP .Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	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 feeling safe to discuss chronic pain and its impact on his/her/their life. EBP 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 and Lambert and *Vol. 2* by Norcross and Wampold). EBP
2. Describe the nature, history, impact, and understood causes of chronic pain. (3, 4)	3. Assess the manifestation of chronic pain, its history, status, triggers, and methods of coping (see *The Handbook of Pain Assessment* by Turk and Melzack). 4. Assess the impact of the pain on the client's functioning in everyday life, including changes in the client's mood, attitude, social, vocational, and familial/marital roles.
3. Complete a thorough medical evaluation to rule out any alternative causes for the pain and reveal any new treatment possibilities. (5)	5. 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. Disclose any history of substance use that may contribute to and complicate the treatment of chronic pain. (6)	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*).
5. Provide behavioral, emotional, and attitudinal information toward an	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 attention

assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)	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). 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. Follow through on a referral to a pain management or rehabilitation program. (11, 12, 13)	11. Give the client information on pain management specialists or rehabilitation programs that are available and help him/her make a decision on whether either option would be a useful therapeutic adjunct. 12. Make a referral to a pain management specialist or clinic of the client's choice and have him/her/them sign appropriate releases for the therapist to have updates on progress from the program and to coordinate services. 13. Elicit from the client a verbal commitment to cooperate with pain management specialists or rehabilitation program.
7. Complete a thorough medication evaluation and review by a prescriber who is a specialist in dealing with chronic pain or headache conditions. (14)	14. Ask the client to complete a medication evaluation and review with a specialist in chronic pain; confer with the prescriber afterward about recommendations and process them with the client toward deciding on the role of medication in the treatment plan.
8. EBT Participate in a cognitive-behavioral group therapy for pain management. (15)	15. Form a small, closed enrollment cognitive-behavioral treatment group (4–8 clients) for pain management (see "Group Therapy for Patients with Chronic Pain" by Keefe et al.); supplement by recommending *Managing Chronic Pain* by Otis; *Managing Pain Before It Manages You* by Caudill). EBT
9. EBT Verbalize an understanding of pain. (16)	16. 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 strategies. EBT
10. EBT Verbalize an understanding of the rationale for treatment. (17, 18)	17. Teach the client a rationale for treatment that helps him/her/them understand that thoughts, feelings, and behavior can affect pain; that there are coping techniques and skills that can be used to help him/her/them to adapt and respond to pain and the resultant problems; emphasize the role that the client can play in managing his/her/their own pain. EBT 18. Assign the client to read material (e.g., sections from books or treatment manuals, online resources) that describe chronic pain conditions and their cognitive-behavioral treatment (e.g., *Managing Chronic Pain* by Otis; *The Chronic Pain Control Workbook* by Catalano and Hardin). EBT
11. EBT Identify and monitor specific pain triggers. (19)	19. 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 type and severity of pain, any apparent triggers of pain, and what was done to try to alleviate the pain (or supplement with "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, the effects of cognitive, affective, and behavioral factors and/or triggers, and the positive or negative effects of the coping strategies he/she is currently using. EBT
12. EBT Learn and implement calming skills such as relaxation, biofeedback, or mindfulness meditation to ease pain. (20, 21, 22, 23, 24)	20. 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 daily life (or supplement with "Deep Breathing Exercise" from the *Adult Psychotherapy Homework Planner* by Jongsma and see *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens). EBT 21. Conduct or refer the client to biofeedback training (e.g., EMG for muscle tension-related pain); assign practice of the skill at home. EBT 22. Identify areas in the client's life where he/she/they can implement skills learned through relaxation or biofeedback. EBT 23. Assign a homework exercise in which the client implements somatic pain management skills and records the result; review and process during the treatment session reinforce gains and problem-solve obstacles toward sustained effective use. EBT 24. As an adjunct to the therapy, 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, et al.; *Living Beyond Your Pain* by Dahl and Lundgren). EBT
13. EBT Incorporate physical therapy into daily routine. (25)	25. Refer the client for physical therapy if pain is heterogeneous (i.e., caused by the complex interplay of nociceptive, neuropathic or mixed pathogenic mechanisms including other chronic medical conditions). EBT
14. EBT Learn mental coping skills and implement with learned somatic skills for managing acute pain. (26)	26. Teach the client distraction techniques (e.g., pleasant imagery, counting techniques, alternative focal point, cognitive diffusion) and how to use them with relaxation skills for the management of acute episodes of pain (or supplement with "Controlling the Focus on Physical Problems" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT
15. EBT Participate in acceptance and commitment therapy for chronic pain. (27)	27. 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/their broader life values, clarify goals and values, and commit to value-driven behavior (see *Acceptance and Commitment Therapy for Chronic Pain* by Dahl et al.). EBT