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

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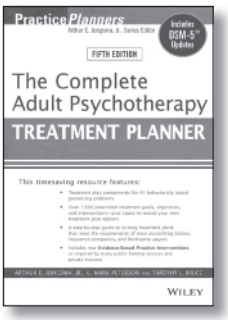

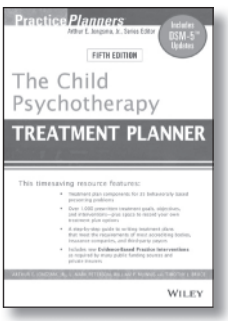

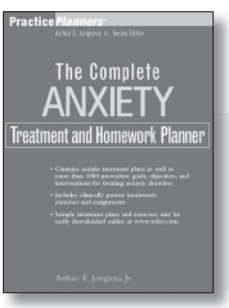

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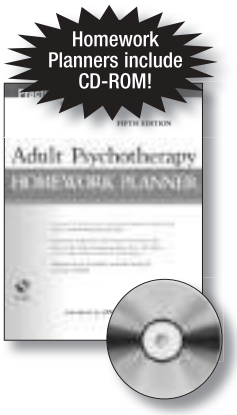

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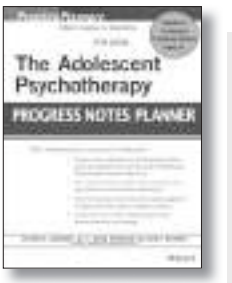

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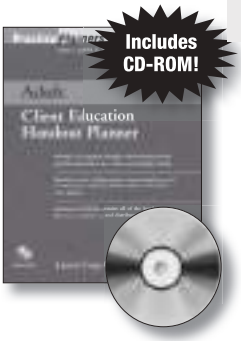

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Complete Planners

The Complete Depression Treatment and Homework Planner
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Practice*Planners*®

Arthur E. Jongsma, Jr., Series Editor

The Addiction Treatment Planner, Fifth Edition

Robert R. Perkinson

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To Tom Moore, who has dedicated his career to bringing high-quality treatment to persons with substance use disorders.

—A.E.J.

To Shane, Nyshie, and Robert, three of the world-changing best.

—R.R.P.

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

—T.J.B.

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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*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fifth editions, but also Treatment Planners targeted to specialty areas of practice, including:

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

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

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

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, 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 adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain forms and resources to aid the clinician in mental health practice management.

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

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

INTRODUCTION

ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

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

Each *Treatment Planner*

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

The *Addiction Treatment Planner* has been written for individual, group, and family counselors and psychotherapists who are working with adults and adolescents who are struggling with addictions to mood-altering chemicals, gambling, abusive eating, nicotine, or sexual promiscuity. The problem list of chapter titles reflects those addictive behaviors and the emotional, behavioral, interpersonal, social, personality, legal, medical, and vocational issues associated with those addictions. Whereas the focus of the original *Chemical Dependence Treatment Planner* was limited exclusively to substance

abuse and its associated problems, the focus of later editions has been expanded to include other common addictive behaviors as well as other behavioral problems and psychiatric conditions in which addictive behavior may occur.

This fifth edition of *The Addition Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based objectives and interventions
- Revised, expanded, and updated professional references (Appendix B)
- Revised, expanded, and updated the self-help book list in the bibliotherapy suggestions (Appendix A)
- More suggested homework assignments integrated into the interventions
- New recovery model (Appendix C) listing Goals, Objectives, and Interventions, allowing a more pointed integration of a recovery model orientation into treatment plans
- New Appendix F, which provides an alphabetical index of sources for the assessment instruments and clinical interview forms that have been cited in chapter interventions
- New chapters on Obsessive-Compulsive Disorder, Self-Harm, Sexual Abuse, and Sleep Disturbance; new objectives and interventions addressing obesity added into the Eating Disorders chapter; and reorganized chapters including Bipolar Disorder and Unipolar Depression
- Integrated *DSM-5 (ICD-10-CM)* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter

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

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

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

Also included (Appendix E) is a form that can be used to assess the client under the six ASAM dimensions. The checklist provides material for efficient evaluation of the client on each of the six dimensions. This form has been developed and is utilized by the staff at Keystone Treatment Center,

Canton, South Dakota, where Dr. Perkinson is the clinical director. It is not copyrighted and may be used or adopted for use by our readers.

Interventions can be found in each chapter that reflect a 12-step recovery program approach, but you will also find interventions based on a broader psychological and pharmacological model. Because addiction treatment is often done in a residential setting through a team approach, interventions have been created that can be assigned to staff members of various disciplines and modalities: nursing, medical, group counseling, family therapy, or individual therapy. We hope that we have provided a broad, eclectic menu of objectives and interventions from which you can select to meet your client's unique needs. Hopefully, we have also provided a stimulus for you to create new objectives and interventions from your own clinical experience that have proven to be helpful to addictive clients.

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

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

The sources listed in the professional references in Appendix B and used to identify the evidence-based treatments integrated into this *Planner* are many. They include supportive studies from the treatment outcome literature; current expert individual, group, and organizational reviews; and

EBP guideline recommendations. Examples of specific sources used include the Cochrane Collaboration reviews, the work of the Society of Clinical Psychology (Division 12 of the American Psychological Association) identifying research-supported psychological treatments, evidence-based treatment reviews such as those in Nathan and Gorman's *A Guide to Treatments That Work* and SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), and EBP guidelines from professional organizations such as the American Psychiatric Association, the National Institute for Health and Clinical Excellence in Great Britain, the National Institute on Drug Abuse (NIDA), and the Agency for Healthcare Research and Quality (AHRQ), to name a few. Although each of these sources uses its own criteria for judging levels of empirical support for any given treatment, we favored those that use more rigorous criteria typically requiring demonstration of efficacy through randomized controlled trials or clinical replication series, good experimental design, and independent replication. Our approach was to evaluate these various sources and include those treatments supported by the highest level of evidence and for which there was consensus in conclusions and/or recommendations. For any chapter in which EBP is indicated, references to the sources used to identify indicated treatments are listed in the professional references (Appendix B), and can be consulted by those interested in further information regarding criteria and conclusions. In addition to these references, this appendix also includes references to clinical resources. Clinical resources are books, manuals, and other resources for clinicians that describe the details of the application or "how to" of the treatment approaches described in a chapter.

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

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

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

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

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

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

These recovery model principles are defined in Appendix C. We have also created a set of Goal, Objective, and Intervention statements that reflect these 10 principles. The clinician who desires to insert into the client treatment plan specific statements reflecting a Recovery Model orientation may choose from this list.

In addition to this list, we believe that many of the Goal, Objective, and Intervention statements found in the chapters reflect a recovery orientation.

For example, our assessment interventions are meant to identify how the problem affects this unique client and the strengths that the client brings to the treatment. Additionally, an intervention statement such as, "Help the client to see the new hope that addiction treatment brings to the resolution of interpersonal conflicts" from the "Suicidal Ideation" chapter is evidence that recovery model content, such as the principle of hope, permeates items listed throughout our chapters. However, if the clinician desires a more focused set of statements directly related to each principle guiding the recovery model, they can be found in Appendix C.

We have done a bit of reorganizing of chapter content for this edition. We have renamed the "Depression" chapter to become "Unipolar Depression." A new chapter entitled "Bipolar Disorder" replaces the previous one entitled "Mania/Hypomania" and now includes interventions for bipolar depression as well as hypomania and mania. We have also deleted the previous chapter entitled "Opioid Dependence" and subsumed its content under a newly titled chapter called "Substance Use Disorders." The "Substance Use Disorders" chapter replaces the previous chapter entitled "Substance Abuse/Dependence," which is in accord with the new *DSM-5* nomenclature and is now more broadly applicable to many types of abuse and dependence. Lastly, we deleted the chapter titled "Attention Deficit/Inattentive Disorder (ADD)" and subsumed much of its content under the two continuing chapters entitled "Attention-Deficit/Hyperactivity Disorder (ADHD)—Adolescent" and "Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult."

With the publication of the *DSM-5* (APA, 2013), we have updated the Diagnostic Suggestions section at the end of each chapter. The *DSM-IV-TR* (APA, 2000) was used in previous editions of this *Planner*. Although many of the diagnostic labels and codes remain the same, several have changed with the publication of the *DSM-5* and are reflected in this *Planner*. We have continued to list *DSM-IV (ICD-9-CM)* codes and diagnostic labels while adding a section of *DSM-5 (ICD-10-CM)* codes and labels describing the disorder, condition, or problem. The date currently set for mandatory use of *DSM-5 (ICD-10-CM)* codes and labels for billing purposes is October 2014.

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

Lastly, some clinicians have asked that the objective statements in this *Planner* be written such that the client's attainment of the objective can be measured. We have written our objectives in behavioral terms and many are measurable as written. For example, this objective from the "Anxiety" chapter is one that is measurable as written because it either can be done or it cannot: "Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment." But at times the statements are too broad to be considered measurable. Consider, for

example, this objective from the "Anxiety" chapter: "Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk." To make it quantifiable a clinician might modify it to read, "Give two examples of identifying, challenging, and replacing biased, fearful self-talk with positive, realistic, and empowering self-talk." Clearly, the use of two examples is arbitrary, but it does allow for a quantifiable measurement of the attainment of the objective. Or consider this example reflecting a behavioral activation objective: "Identify and engage in pleasant activities on a daily basis." To make it more measurable the clinician might simply add a desired target number of pleasant activities, thus: "Identify and report engagement in two pleasant activities on a daily basis." The exact target number that the client is to attain is subjective and should be selected by the individual clinician in consultation with the client. Once the exact target number is determined, then our content can be very easily modified to fit the specific treatment situation. For more information on psychotherapy treatment plan writing, see Jongsma (2005).

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

HOW TO USE THIS TREATMENT PLANNER

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

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems or treatment will lose its direction. Choose the problem within this *Planner* that most accurately represents your client's presenting issues.
2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-IV-TR* or the International Classification of Diseases. This *Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.

3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.
4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.
5. **Intervention Creation.** Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the provider to write other interventions reflecting his or her own training and experience.

   Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. Many references to homework interventions are found in each chapter. The sources for these assignments can be found in the books listed in the general references at the beginning of Appendix A. For further information about self-help books, mental health professionals may wish to consult *Self-Help That Works: Resources to Improve Emotional Health and Strengthen Relationships* (Norcross et al., 2013).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-IV-TR*. Despite arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. It is the clinician's thorough knowledge of *DSM-IV-TR* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate

implementation and presentation to the client. A sample treatment plan for Substance Use is provided at the end of this introduction.

A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

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

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SAMPLE TREATMENT PLAN

SUBSTANCE USE DISORDER

Definitions: Demonstrates a maladaptive pattern of substance use, manifested by increased tolerance and withdrawal.
Fails to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
Denies that chemical dependence is a problem, despite feedback from significant others that the use of the substance is negatively affecting the client and others.
Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance.
Exhibits physical withdrawal symptoms (e.g., shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when going without the substance for any length of time.
Reports suspension of important social, recreational, or occupational activities because they interfere with using.

Goals: Establish and maintain total abstinence, while increasing knowledge of the disease and the process of recovery.
Acquire the necessary 12-step skills to maintain long-term sobriety from all mood-altering substances, and live a life free of substance abuse.

OBJECTIVES	INTERVENTIONS
1. Provide honest and complete information for a chemical dependence biopsychosocial history.	1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her use, signs and symptoms of use, and negative life consequences such as social, legal, familial, and vocational problems.
2. Participate in a medical evaluation to assess the effects of chemical dependence.	1. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence (include tests for HIV, hepatitis, and sexually transmitted diseases).

3. Explore and resolve ambivalence associated with commitment to change behaviors related to substance use and addiction.	1. Conduct Motivational Interviewing to assess the client's stage of preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Motivational Interviewing* by Miller and Rollnick; *Motivational Interviewing and Enhancement* by DiClemente, Van Orden, and Wright). 2. Ask the client to make a list of the ways substance abuse has negatively impacted his/her life (e.g., personally, medically, relationally, legally, vocationally, and socially) and the positive impact nonuse may have (or assign "Substance Abuse's Negative Impact Versus Sobriety's Positive Impact" in the *Adult Psychotherapy Homework Planner* by Jongsma; or "Consequences of Continuing Addictive Lifestyles" in the *Addiction Treatment Homework Planner* by Finley and Lenz). 3. Assign the client to complete an Alcoholics Anonymous Step 1 paper admitting to powerlessness over mood-altering chemicals, and present it in group therapy or to therapist for feedback (see *The Alcoholism & Drug Abuse Client Workbook* by Perkinson).
4. Commit self to an action plan directed toward termination of substance use.	1. Encourage and support the client's self-efficacy for change toward the goal of developing an action plan for termination of substance use to which the client is willing to commit. 2. Assign the client to write a list of

	reasons to be abstinent from addiction (or assign "Making Change Happen" or "A Working Recovery Plan" in the *Addiction Treatment Homework Planner* by Finley and Lenz). 3. Develop an abstinence contract with the client regarding the termination of the use of his/her drug of choice; process client's feelings related to the commitment.
5. Attend Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings as frequently as necessary to support sobriety.	1. Recommend that the client attend AA or NA meetings and report on the impact of the meetings; process messages the client is receiving.
6. Verbalize increased knowledge of alcoholism and the process of recovery.	1. Conduct or assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence; ask him/her to identify several key points attained from each didactic and process these points.
7. Cooperate with exploration of increasing satisfaction in areas of life that can support sobriety such as employment, recreation, and relationships.	1. Facilitate development of a plan for the client to change his/her living situation to foster recovery (or assign "Assessing My Needs" in the Addiction Treatment Homework Planner by Finley and Lenz); revisit routinely and facilitate toward accomplishing a positive change in living situation. 2. Assist the client in identifying new sources of nondrinking recreation and social friendships (or assign "Alternatives to Addictive Behavior" in the *Addiction Treatment Homework Planner* by Finley and Lenz); use problem-solving and communication skills to overcome obstacles.

	3. Direct conjoint sessions that address and resolve issues with a partner so as to increase the number of pleasant interactions and reduce conflicts.
8. Participate in behavioral couples therapy designed to increase the non-substance-using partner's reinforcement of sobriety and to reduce relationship conflict.	1. Develop a sobriety contract with the couple that stipulates an agreement to remain abstinent, limits the focus of partner discussions to present-day issues not past hurtful behaviors, identifies the role of AA meetings, and schedules a daily time to share thoughts and feelings. 2. Ask each partner to make a list of pleasurable activities that could be engaged in together to increase positive feelings toward each other (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the list and assign implementation of one or more activities before the next session. 3. Teach the couple problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties' satisfaction with the action, adjust action if necessary); role-play the use of these skills applied to real-life issues of conflict for the couple (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma). 4. In light of the recovery contract, review the client's sobriety experience and the couples'

	interaction since the last session; address any relationship conflicts, assisting the couple in improving their communication skills (e.g., "I messages," reflective listening, eye contact, respectful responding, etc.) by using role-play in the session.
9. Earn rewards by submitting drug-negative urine samples.	1. Implement a prize-based contingency management system for drug free living by rewarding the client's drug-negative urine samples with desired prizes starting at the low end of a $1–$100 range and increasing with continued abstinence (see *Contingency Management for Substance Abuse Treatment* by Petry).
10. Implement relapse prevention strategies for managing possible future situations with high risk for relapse.	1. Implement relapse prevention strategies for managing possible future situations with high risk for relapse. 2. Assist the client in developing a detailed, written recovery plan (e.g., treatment activities, daily routine, basic self-care, relationships, spirituality, work stress, finances, family issues, etc.) that will identify supports and strategies that will be used in maintaining sobriety (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

DIAGNOSIS

Using DSM-IV/ICD-9-CM:

303.90 Alcohol Dependence

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

F10.20 Alcohol Use Disorder, Moderate

ADULT-CHILD-OF-AN-ALCOHOLIC (ACA) TRAITS

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

1. Implement a plan for recovery from addiction that reduces the impact of ACA traits on sobriety.
2. Decrease dependence on relationships while beginning to meet his/her own needs.
3. Reduce the frequency of behaviors that are exclusively designed to please others.
4. Choose partners and friends who are responsible, respectful, and reliable.
5. Overcome fears of abandonment, loss, and neglect.
6. Understand the feelings that resulted from being raised in an ACA environment and reduce feelings of alienation.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Acknowledge the feelings of powerlessness that result from ACA traits and addiction. (1)	1. Probe the feelings of powerlessness that the client experienced as a child in the alcoholic home, and explore similarities to his/her feelings when abusing chemicals.
2. Verbalize the relationship between being raised in an addictive family and how this behavior is repeated in addiction. (2)	2. Teach the client the relationship between his/her childhood experience in an addictive family and how this increased the likelihood of repeating the addictive behavior pattern as an adult.
3. Complete psychological testing or objective questionnaires for assessing traits associated with being an adult child of an alcoholic. (3)	3. Administer to the client psychological instruments designed to objectively assess the strength of traits associated with being an adult child of an

	alcoholic (e.g., Symptom Checklist-90-Revised, Children of Alcoholics Screening Test); give the client feedback regarding the results of the assessment and readminister if necessary to assess treatment progress.
4. Verbalize the rules of "don't talk, don't trust, don't feel," which were learned as a child, and how these rules have made interpersonal relationships more difficult. (4, 5)	4. Explore how the dysfunctional family rules led to uncomfortable feelings and an escape into addiction. 5. Educate the client about the ACA rules of "don't talk, don't trust, and don't feel"; explain how these rules make healthy relationships more difficult.
5. Verbalize an understanding of how ACA traits contributed to addiction. (6, 7)	6. Have the client list five ways that ACA traits led to addiction (or assign the client to complete "Addressing ACA Traits in Recovery" from the *Addiction Treatment Homework Planner* by Finley and Lenz). 7. Assist the client in identifying his or her ACA traits and the relationship between ACA traits and addiction.
6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)	8. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described,

is not concerned, and has no motivation to change).

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

7. Identify the causes of the fear of abandonment that were experienced in the alcoholic home. (12, 13)

12. Probe the client's fear of violence, abandonment, unpredictability, and embarrassment when the parent was mentally unstable or abusing chemicals.
13. Explore specific situations when the client experienced fear of

abandonment or feelings of rejection during childhood.

8. Identify how the tendency to take care of others in interpersonal relationships is related to maintaining a feeling of security and control. (14, 15)

14. Assist the client in understanding how his/her early childhood experiences led to fears of abandonment, rejection, neglect, and an assumption of the caretaker role, which is detrimental to intimate relationships.

15. Assist the client in identifying the many ways in which he/she takes on the parental role of caregiver.

9. Share the feeling of worthlessness that was learned in the alcoholic home, and directly relate this feeling to abuse of substances as a coping mechanism. (16, 17)

16. Explore the client's feelings of worthlessness and shame, assessing specific painful situations.

17. Teach the client how low self-esteem results from being raised in an alcoholic home, due to experiencing emotional rejection, broken promises, abuse, neglect, poverty, and lost social status.

10. List 10 reasons for increased feelings of self-worth. (18, 19)

18. Assign the client to list his/her positive traits and accomplishments; reinforce these as a foundation for building self-esteem.

19. Emphasize to the client his/her inherent self-worth as a human being and show the benefits of using a higher power in recovery.

11. Identify the pattern in the alcoholic family of being ignored or punished when honest feelings were shared. (5, 20)

5. Educate the client about the ACA rules of "don't talk, don't trust, don't feel"; explain how these rules make healthy relationships more difficult.

20. Probe how the client's family responded to expressions of feelings, wishes, and wants and why it became dangerous for the client to share feelings with

	others (or assign the client to complete the "Understanding Family History" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).
12. List five qualities and behaviors that should be evident in others before interpersonal trust can be built. (21)	21. Assist the client in developing a set of character traits to be sought in others (e.g., honesty, sensitivity, kindness) that qualify them as trustworthy.
13. Increase the frequency of telling the truth rather than saying only what the client thinks the other person wants to hear. (22, 23)	22. Teach the client that the behavior of telling other people what we think they want to hear rather than speaking the truth is based on fear of rejection, which was learned in the alcoholic home; use modeling, role-playing, and behavior rehearsal to teach the client more honest communication skills.
	23. Assign the client to keep a journal of incidents in which he/she told the truth rather than saying only what others wanted to hear.
14. List the steps to effectively and independently solving problems. (24)	24. Teach the client problem-solving skills (e.g., identify the problem, brainstorm alternate solutions, examine the advantages and disadvantages of each option, select an option, implement a course of action, and evaluate the result); role-play solving a current problem in his/her life (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).
15. Acknowledge the resistance to sharing personal problems; share at least one problem in each therapy session. (5, 25, 26, 27)	5. Educate the client about the ACA rules of "don't talk, don't trust, don't feel"; explain how these rules make healthy relationships more difficult.

25. Probe how the client's family responded to expressions of feelings, wishes, and wants and why it became dangerous for the client to share feelings with others.
26. Educate the client about healthy interpersonal relationships based on openness, respect, and honesty; explain the necessity of sharing feelings to build trust and mutual understanding (or assign the client to complete the honesty exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
27. Explore the client's pattern of resistance to sharing personal problems and preferring, instead, to focus on helping others with their problems.

16. Verbalize an understanding of how ACA traits contribute to choosing partners and friends that have problems and need help. (14, 28)

14. Assist the client in understanding how his/her early childhood experiences led to fears of abandonment, rejection, neglect, and an assumption of the caretaker role, which is detrimental to intimate relationships.
28. Help the client to understand that his/her strong need to help others is based on low self-esteem and the need for acceptance, which was learned in the alcoholic family of origin; relate this caretaking behavior to choosing friends and partners who are chemically dependent and/or psychologically disturbed.

17. Initiate the encouragement of others in recovery, to help reestablish a feeling of self-worth. (29, 30)

29. Teach the client that active involvement in a recovery group can aid in building trust in others and confidence in himself/herself.

30. Assist the client in developing an aftercare plan that is centered on regular attendance at Adult Children of Alcoholics, Alcoholics Anonymous, and Narcotics Anonymous (ACA/AA/NA) meetings.

18. List reasons why regular attendance at recovery group meetings is necessary to arrest ACA traits and addiction. (31)

31. Assist the client in listing reasons why 12-step recovery group attendance is helpful to overcome ACA traits.

19. Discuss fears that are related to attending recovery group meetings, and develop specific written plans to deal with each fear. (32)

32. Probe the relationship between ACA traits and the fear of attending recovery group meetings; assist the client in developing coping strategies to cope with the fear (e.g., give self-positive messages regarding self-worth, use relaxation techniques to reduce tension, use meditation to induce calm and support from a higher power).

20. Verbalize how a recovery group can become the healthy family that one never had. (33, 34, 35)

33. Teach the client that active involvement in a recovery group can aid in building trust in others and confidence in himself/herself.

34. Discuss how the home group of ACA/AA/NA can function as the healthy family the client never had; help him/her realize why he/she needs such a family to recover.

35. Educate the client about the family atmosphere in a home ACA/AA/NA recovery group, and how helping others can aid in recovery and reestablish a feeling of worth.

21. List five ways in which belief in, and interaction with, a higher power can reduce fear and aid in recovery. (36, 37)

36. Teach the client how faith in a higher power can aid in recovery and arrest ACA traits and addiction (or assign the client to

complete the Step 2 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

37. Assign the client to read the Adult Children of Alcoholics *Red Book* and the Alcoholics Anonymous *Big Book* on the topic of spirituality and the role of a higher power; process the material in an individual or group therapy session.

22. Verbalize the feeling of serenity that results from turning out-of-control problems over to a higher power. (38)

38. Review problematic circumstances in the client's life that could be turned over to a higher power to increase serenity.

23. Practice assertiveness skills and share how these skills were used in interpersonal conflict. (39, 40)

39. Use modeling, behavior rehearsal, and role-playing to teach the client healthy, assertive skills (or assign "Making Your Own Decisions" in the *Adult Psychotherapy Homework Planner* by Jongsma); apply these skills to several current problem situations, and then ask the client to journal his/her assertiveness experiences.

40. Teach the client the assertive formula of "I feel ____ when you ____. I would prefer it if ____"; role-play several applications in his/her life and then assign him/her to use this formula three times per day.

24. Share the personal experiences of each day with one person that day. (41, 42)

41. Teach the client the *share check* method of building trust, in which the degree of shared information is related to a proven level of trustworthiness; use behavior rehearsal of several situations in which the client shares feelings.

42. Review and reinforce instances when the client has shared honestly and openly with a trustworthy person.

25. Cooperate with a physician's evaluation for psychopharmacological intervention. (43)

43. Refer the client to a physician to evaluate whether psychopharmacological interventions are warranted.

26. Take medications as prescribed, and report on their effectiveness and side effects. (44, 45)

44. Medical staff administers medications to the client as prescribed.

45. Monitor the client's medications for effectiveness and side effects.

27. Develop a 5-year plan to recover from substance abuse and ACA traits. (46)

46. Assist in the client developing a 5-year plan to recover from substance abuse and ACA traits.

28. Complete a survey to assess the degree of satisfaction with treatment. (47)

47. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	300.02	Generalized Anxiety Disorder
	300.00	Anxiety Disorder NOS
	309.81	Posttraumatic Stress Disorder
	V61.20	Parent–Child Relational Problem
	_____	_____
	_____	_____

Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.4	F34.1	Persistent Depressive Disorder
300.02	F41.1	Generalized Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
309.81	F43.10	Posttraumatic Stress Disorder
V61.20	Z62.820	Parent–Child Relational Problem
301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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

ANGER

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. Has a history of explosive, aggressive outbursts, particularly when intoxicated, that lead to assaultive acts or destruction of property.
4. Abuses substances to cope with angry feelings and to relinquish responsibility for aggression.
5. 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).
6. Shows direct or indirect evidence of physiological arousal related to anger.
7. Reports a history of explosive, aggressive outbursts out of proportion with any precipitating stressors, leading to verbal attacks, assaultive acts, or destruction of property.
8. Displays overreactive verbal hostility to insignificant irritants.
9. Engages in physical and/or emotional abuse against significant other.
10. Makes swift and harsh judgmental statements to or about others.
11. Displays body language suggesting anger, including tense muscles (e.g., clenched fist or jaw), glaring looks, or refusal to make eye contact.
12. Shows passive-aggressive patterns (e.g., social withdrawal, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, uncooperative in meeting expected behavioral norms) due to anger.
13. Passively withholds feelings and then explodes in a rage.
14. Demonstrates an angry overreaction to perceived disapproval, rejection, or criticism.
15. Uses abusive language meant to intimidate others.
16. Rationalizes and blames others for aggressive and abusive behavior.
17. Uses aggression as a means of achieving power and control.

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LONG-TERM GOALS

1. Maintain a program of recovery that is free of addiction and violent behavior.
2. Decrease the frequency, intensity, and duration of angry thoughts, feelings, and actions and increase the ability to recognize and respectfully express frustration and resolve conflict.
3. Implement cognitive behavioral skills necessary to solve problems in a less aggressive and more constructive manner.
4. Stop blaming others for problems, and accept responsibility for own feelings, thoughts, and behaviors.
5. Learn and implement anger management skills to reduce the level of stress and the irritability that accompanies it.
6. Learn the assertive skills that are necessary to reduce angry feelings and solve problems in a less aggressive and more constructive manner.
7. Become capable of handling angry feelings in constructive ways that enhance daily functioning.

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SHORT-TERM OBJECTIVES

1. Identify situations, thoughts, feelings that trigger anger, angry verbal, and/or behavioral actions and the targets of those actions. (1, 2)

THERAPEUTIC INTERVENTIONS

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

	impact anger expression has had on his/her life as the interview focuses on the impact of anger on the client's life.
	2. Ask the client to describe his/her history and nature of anger issues in his/her own words; thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
2. Complete psychological testing or objective questionnaires for assessing anger expression. (3)	3. Administer to the client psychometric instruments designed to objectively assess anger expression (e.g., Anger, Irritability, and Assault Questionnaire, Buss-Durkee Hostility Inventory; State-Trait Anger Expression Inventory); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.
3. Verbalize an understanding of how angry thoughts and feelings can lead to increased risk of addiction. (4, 5)	4. Educate the client about his/her tendency to engage in addictive behavior as a means of relieving uncomfortable feelings; develop a list of several instances of occurrence.
	5. Teach the client about high-risk situations of strong negative emotions, social pressure, interpersonal conflict, strong positive emotions, and testing of personal control; discuss how anger, as a strong negative emotion, places him/her at a high risk for addiction.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
6. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

5. Cooperate with a physician's evaluation regarding whether psychopharmacological intervention is warranted; take medications consistently, if prescribed. (10, 11)

10. 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.

11. Monitor the client for prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.

6. Keep a daily journal of persons, situations, and other triggers of anger; record thoughts, feelings, and actions taken. (12)

12. Ask the client to self-monitor, keeping an ongoing log of situations that precipitate angry feelings, noting the thoughts, feelings, intensity, and duration of anger (rate on a scale), and any actions taken in anger (or assign "Anger Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma; "Is My Anger Due to Feeling Threatened?" or "Is My Anger Due to Unmet Expectations?" in the *Addiction Treatment Homework Planner* by Finley and Lenz); review the log to help the client understand the causes and extent of his/her anger.

7. Verbalize increased awareness of anger expression patterns. (13, 14)

13. Assist the client in reconceptualizing anger as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases (e.g., demanding expectations not

being met leading to increased arousal and anger leading to acting out) that can be challenged and changed.

14. Assist the client in generating a list of anger triggers; process the list and other relevant journal material toward helping the client understand how cognitive, physiological, and affective factors interplay to produce anger.

8. Explore motivation and willingness to participate in therapy, and agree to participate to learn new ways to think about and manage anger. (15, 16, 17)

15. Ask the client to list and discuss ways anger has negatively impacted his/her daily life (e.g., hurting others or self, legal conflicts, loss of respect from self and others, destruction of property); process this list.

16. Assist the client in identifying the positive consequences of managing anger (e.g., respect from others and self, cooperation from others, improved physical health, etc.) (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma).

17. Use motivational interviewing techniques to help the client clarify his/her motivational stage, moving the client to the action stage in which he/she agrees to learn new ways to conceptualize and manage anger.

9. Verbalize an understanding of how the treatment is designed to decrease anger and improve quality of life. (18)

18. Discuss the rationale for treatment, emphasizing how functioning can be improved through change in the various dimensions of anger; revisit relevant themes throughout therapy to help the client

	consolidate his/her understanding (see *Overcoming Situational and General Anger: Therapist Protocol* by Deffenbacher and McKay; *Anger Management* by Kassinove and Tafrate).
10. Agree to learn new alternative ways to recognize and manage anger. (19)	19. Ask the client to agree to learn new ways to recognize and manage anger.
11. Read a book or treatment manual that supplements the therapy by improving understanding of anger and anger control problems. (20)	20. Assign the client to read material that educates him/her about anger and its management (e.g., *Overcoming Situational and General Anger: Client Manual* by Deffenbacher and McKay, *Of Course You're Angry* by Rosselini and Worden, *The Anger Control Workbook* by McKay, or *Anger Management for Everyone* by Kassinove and Tafrate); process and revisit relevant themes throughout therapy to help the client consolidate his/her understanding of the treatment.
12. Learn calming strategies as part of managing reactions to frustration. (21)	21. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing-induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation, mindful breathing) as part of a tailored strategy for reducing chronic and acute physiological tension that accompanies the escalation of his/her angry feelings.
13. Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a less angry reaction. (22, 23, 24)	22. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should*, *must*, or *have to* statements); identify and challenge biases,

assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration. Combine new self-talk with calming skills as part of a set of coping skills to manage anger.

23. Assign the client a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions; review; reinforce success, providing corrective feedback toward improvement (or assign the client to complete "Correcting Distorting Thinking" from the *Addiction Treatment Homework Planner* by Finley and Lenz).

24. Role-play the use of relaxation and cognitive coping to visualize anger-provoking scenes, moving from low- to high-anger scenes; assign the implementation of calming techniques in his/her daily life and when facing anger-triggering situations; process the results, reinforcing success and problem-solving obstacles.

14. Learn and implement thought-stopping to manage intrusive unwanted thoughts. (25)

25. Assign the client to implement a thought-stopping technique in which he/she shouts STOP to himself/herself in his/her mind and then replaces the thought with an alternative that is calming (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review implantation, reinforcing success

and providing corrective feedback for failure.

15. Learn to verbalize feelings of anger in a controlled, assertive way. (26)

26. Use instruction, modeling, and/or role-playing to teach the client the distinctive elements as well as the pros and cons of assertive, unassertive (passive), and aggressive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction.

16. Learn and implement problem solving and/or conflict resolution skills to manage interpersonal problems. (27, 28, 29)

27. 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).

28. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts.

29. Conduct conjoint sessions to help the client implement assertion, problem-solving, and/or conflict resolution skills in the presence of his/her significant others.

17. Combine learned anger management skills into a new approach to handling frustration. (30)

30. Assist the client in adopting a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to their needs.

18. Practice using new anger management skills in session with the therapist and during homework exercises. (31, 32)

19. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (33)

20. Learn and implement relapse prevention strategies. (34, 35, 36, 37, 38)

31. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing anger.

32. Use any of several techniques, including imagery, behavioral rehearsal, modeling, role-playing, or in vivo exposure/behavioral experiments to help the client consolidate the use of his/her new anger management skills.

33. Monitor angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the use of the client's new anger management skills (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma); review data; reinforce success; provide corrective feedback toward improvement.

34. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible angry outburst and relapse with the choice to return routinely to his/her old pattern of anger.

35. Identify and rehearse with the client the management of future situations or circumstances in which lapses back into inappropriate anger could occur.

36. Instruct the client to routinely use new anger management strategies learned in therapy (e.g., calming, adaptive self-talk, assertion, and/or conflict resolution) to respond to frustrations.

37. Develop a coping card or other reminder on which new anger management skills and other important information (e.g., "Calm yourself," "Be flexible in your expectations of others," "Voice your opinion calmly," "Respect others' points of view") are recorded for the client's later use.

38. Schedule periodic maintenance sessions to help the client maintain therapeutic gains.

21. Identify social supports that will help facilitate the implementation of anger management skills. (39)

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

22. Participate in Acceptance and Commitment Therapy (ACT) for learning a new approach to anger and anger management. (40, 41, 42, 43)

40. Use an ACT approach to help the client experience and accept the presence of worrisome thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).

41. Teach mindfulness meditation to help the client recognize the negative thought processes associated with anger and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing but not reacting to non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).

42. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

43. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy* by Hayes).

23. Verbalize an understanding of the relationship between the feelings of worthlessness and hurtfulness that were experienced in the family of origin and the current feelings of anger. (44, 45)

44. Probe the client's experience with his/her family of origin and help him/her to see how these experiences led to a tendency to see people and situations as dangerous and threatening.

45. Assist the client in identifying ways that key life figures (e.g., father, mother, teachers) have expressed angry feelings and how these experiences have positively or negatively influenced the way he/she handles anger.

24. Verbalize an understanding of how anger has been reinforced as a coping mechanism for stress. (46)

46. Teach the client how anger blocks the awareness of pain, discharges uncomfortable feelings, erases guilt, and places the blame for problems on others.

25. Verbalize an understanding of the need for and process of forgiving others so as to reduce anger. (47)

47. Assist the client in identifying whom he/she needs to forgive, and educate him/her as to the long-term process that is involved in forgiveness versus a magical single event; recommend reading books on forgiveness (e.g., *Forgive and Forget* by Smedes); review the client's progress, reinforce success, and assess its impact on anger reduction.

26. Verbalize an understanding of the concept of a higher power and the benefits of acceptance of such a concept. (48)

27. Implement regular physical exercise to reduce tension. (49)

28. Attend 12-step recovery group meetings regularly, and share feelings with others there. (50)

29. Develop a long-term plan to recover from substance abuse and anger. (51)

30. Complete a survey to assess the degree of satisfaction with treatment. (52)

48. Teach the client about the 12-step recovery program concept of a higher power, and how to turn over perpetrators of pain to his/her higher power for judgment.

49. Teach the client the benefits of regular physical exercise; assign a program of implementation.

50. Teach the client the importance of actively attending 12-step recovery meetings, getting a sponsor, reinforcing people around him/her, and sharing feelings.

51. Assist the client in developing a 5-year personal recovery plan.

52. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.34	Intermittent Explosive Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.8	Conduct Disorder
	310.1	Personality Change Due to Axis III Disorder
	309.81	Posttraumatic Stress Disorder
	V61.12	Physical Abuse of Adult (by Partner)

	V61.83	Physical Abuse of Adult (by Nonpartner)
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	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

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

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

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

ANTISOCIAL BEHAVIOR

BEHAVIORAL DEFINITIONS

1. Has a history of breaking the rules or the law (often under the influence of drugs or alcohol) to get his/her own way.
2. Exhibits a pervasive pattern of disregard for and violation of the rights of others.
3. Consistently blames other people for his/her own problems and behaviors.
4. Uses aggressive behavior to manipulate, intimidate, or control others.
5. Demonstrates a chronic pattern of dishonesty.
6. Lives a hedonistic, self-centered lifestyle, with little regard for the needs and welfare of others.
7. Verbalizes a lack of empathy for the feelings of others, even if they are friends or family.
8. Presents a pattern of criminal activity and addiction, going back to one's adolescent years.
9. Engages in dangerous, thrill-seeking behavior, without regard for the safety of self or others.
10. Makes decisions impulsively, without giving thought to the consequences for others.

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LONG-TERM GOALS

1. Develop a program of recovery that is free from addiction and the negative influences of antisocial behavior.

2. Learn the importance of helping others in recovery.
3. Learn how antisocial behavior and addiction is self-defeating.
4. Understand criminal thinking and develop self-talk that respects the welfare and rights of others.
5. Understand the importance of a program of recovery that demands rigorous honesty.
6. Take responsibility for one's own behavior.

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SHORT-TERM OBJECTIVES

1. Verbalize an acceptance of powerlessness and unmanageability over antisocial behavior and addiction. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing antisocial behavior. (3)

THERAPEUTIC INTERVENTIONS

1. Help the client to understand the self-defeating nature of antisocial behavior and addiction (or assign the Step 1 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Help the client to see the relationship between antisocial behavior and addiction.

3. Administer to the client psychological instruments designed to objectively assess antisocial behavior, impulsivity, and/or aggression rating instruments (e.g., Psychopathy Checklist-Revised; Aggressive Acts Questionnaire; Barratt Impulsiveness Scale-11); give the client feedback regarding the results of the assessment and test again, if necessary, to assess treatment progress.

3. State how antisocial behavior and addiction are associated with irrational thinking (Alcoholics Anonymous's "insanity"). (4)

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

4. Help the client to understand how doing the same things over and over but expecting different results is irrational—what Alcoholics Anonymous calls "insanity."

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Consistently follow all rules. (9)	9. Assign appropriate consequences when the client fails to follow rules or expectations.
6. Identify and verbalize the negative consequences that failure to comply with the rules/limits has had on self and others. (10, 11, 12)	10. Review with the client several examples where his/her rule and/or limit breaking led to negative consequences to self and others.
	11. Use role reversal techniques to sensitize the client to his/her lack of empathy for others by revisiting the consequences of his/her behavior on others (or assign "How I Have Hurt Others" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	12. Teach the client that many negative consequences are preceded by decisions that are based on criminal thinking; ask the client to list five times when antisocial behavior led to negative consequences and list the many decisions that were made along the way.
7. List the ways dishonesty is self-defeating. (13)	13. Assist the client in understanding why dishonesty results in more lies, loss of trust from others, and, ultimately, rejection.

8. List the reasons why criminal activity leads to a negative self-image. (14)

9. Verbalize how criminal thinking is used to avoid responsibility and to blame others. (15)

10. Decrease the frequency of statements blaming others or circumstances while increasing the frequency of statements accepting responsibility for one's own behavior, thoughts, and feelings. (16, 17, 18)

11. Develop a list of prosocial behaviors and practice one of these behaviors each day. (19)

12. Write a list of typical criminal thoughts; then replace each thought with one that is respectful of self and others. (20, 21)

14. Help the client understand why criminal activity leads to feelings of low self-esteem (e.g., loss of respect from others, broken relationships, legal problems, lack of achievement).

15. Teach the client how criminal thinking (e.g., superoptimism, little empathy for others, power orientation, sense of entitlement, self-centeredness) avoids personal responsibility and leads to blaming others.

16. Help the client to understand how blaming others results in a failure to learn from one's mistakes and, therefore, making the same mistakes over again.

17. Explore with the client the reasons for blaming others for one's own problems and behaviors, and how he/she may have learned this behavior in a punishing family environment.

18. Confront the client's projection of blame for his/her behavior, feelings, and thoughts; reinforce his/her acceptance of personal responsibility.

19. Teach the client the difference between antisocial and prosocial behaviors, then help him/her develop a list of prosocial behaviors (e.g., helping others) to practice each day.

20. Confront the client's antisocial beliefs about his/her lack of respect for the rights and feelings of others, and model thoughtful attitudes and beliefs about the welfare of others.

21. Assist the client in identifying his/her typical antisocial

	thoughts; list an alternate, respectful, and trusting empathic thought.
13. List five ways Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings and a higher power can assist in overcoming antisocial behavior and addiction. (22)	22. Discuss with the client the various ways recovery groups and a belief in a higher power can assist him/her in recovery (e.g., provide emotional support, provide social relationships, relieve anxiety, reinforce self-worth, provide guidance) (or assign the Step 3 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
14. Receive feedback/redirection from staff/therapist without making negative gestures or remarks. (23)	23. Confront the client when he/she breaks the rules, blames others, or makes excuses.
15. Develop a written plan to address all pending legal problems in a constructive manner. (24)	24. Assist the client in addressing each legal problem honestly, taking responsibility for his/her behavior.
16. Encourage at least one person in recovery each day. (25, 26)	25. Teach the client why it is essential to attend recovery groups and to learn how to help others.
	26. Using modeling, role-playing, and behavior rehearsal, practice with the client how he/she can encourage others in recovery.
17. Articulate the antisocial and addiction behaviors that have resulted in pain and disappointment to others and, therefore, a loss of their trust. (27, 28, 29)	27. Assist the client in developing a list of reasons why the trust of others is important as a basis for any relationship.
	28. Help the client identify prosocial behaviors that will result in benefits that he/she sought from addictive behaviors (or assign "Alternatives to Addictive Behavior" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

29. Confront any denial of responsibility for irresponsible, self-centered, and impulsive behaviors (or assign "Letter of Apology" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. Verbalize a desire to keep commitments to others and list ways to prove oneself to be responsible, reliable, loyal, and faithful. (30)

30. Discuss with the client the importance of keeping commitments and promises to others and ways to prove himself/herself as trustworthy in relationships.

19. Write an aftercare plan that includes a sponsor, AA meetings, and counseling. (31, 32)

31. Introduce the client to his/her AA/NA sponsor or encourage him/her to ask a stable recovery person to be a sponsor; teach him/her the many ways a sponsor can be used in recovery.

32. Help the client develop an aftercare program that specifically outlines what AA meetings will be attended, the psychotherapist he/she will be working with, and how a daily inventory will be taken (or assign "Taking Daily Inventory" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

20. Family members develop an aftercare plan that focuses on what they are expected to do to help the client recover. (33, 34, 35, 36)

33. Teach the family members about criminal thinking and show them how to help the client correct his/her inaccurate thoughts.

34. Teach the family the need to overcome their denial of making excuses for reinforcing or being intimidated by the client's antisocial behavior.

35. Use behavior rehearsal, modeling, and role-playing to teach the family members conflict resolution skills.

36. Assist each family member in identifying and listing how to encourage the client to recover from antisocial behavior and addiction.

21. Develop a 5-year written personal recovery plan to address addiction and antisocial traits. (37)

37. Assist the client in developing a 5-year personal recovery plan.

22. Complete a survey to assess the degree of satisfaction with treatment. (38)

38. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	309.3	Adjustment Disorder With Disturbance of Conduct
	312.34	Intermittent Explosive Disorder
	V71.01	Adult Antisocial Behavior
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.8	F91.x	Conduct Disorder
313.81	F91.3	Oppositional Defiant Disorder
309.3	F43.24	Adjustment Disorder With Disturbance of Conduct
312.34	F63.81	Intermittent Explosive Disorder
V71.01	Z72.811	Adult Antisocial Behavior
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

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

ANXIETY

BEHAVIORAL DEFINITIONS

1. Excessive and/or unrealistic worry that is difficult to control, occurring more days than not for at least 6 months about a number of events or activities.
2. Motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
3. Autonomic hyperactivity (e.g., palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, diarrhea).
4. Hypervigilance (e.g., feeling constantly on edge, experiencing concentration difficulties, having trouble falling or staying asleep, exhibiting a general state of irritability).
5. Demonstrates excessive worry regarding several life circumstances that has no factual or logical basis.
6. Excessive worries about family, job, social interactions, and/or health.
7. Has a tendency to blame self for the slightest imperfection or mistake.
8. Abuses substances in an attempt to control anxiety symptoms.

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LONG-TERM GOALS

1. Maintain a program of recovery, free from addiction and excessive anxiety.
2. End addiction as a means of escaping anxiety and practice constructive coping behaviors.

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

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SHORT-TERM OBJECTIVES

1. Describe the history of anxiety symptoms. (1, 2)
2. Acknowledge the powerlessness and unmanageability caused by excessive anxiety and addiction. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Develop a level of trust with the client toward creating a good working alliance; provide support and empathy to encourage the client to feel safe in expressing his/her experiences with anxiety.
2. Assess the client's frequency, intensity, duration, and history of panic symptoms, fear, and avoidance (e.g., the Anxiety Disorders Interview Schedule–Adult Version) (or assign "Anxiety Triggers and Warning Signs" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
3. Help the client to see how anxiety and powerlessness over addiction has made his/her life unmanageable.

4. Teach the client about the relationship between anxiety and addiction (e.g., how the substance was used to treat the anxious symptoms, why more substance use became necessary) (or assign "Coping With Stress" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

3. Complete psychological testing or objective questionnaires for assessing the client's anxiety. (5)

5. Administer psychological tests or objective measures to help assess the nature and degree of the client's worry and anxiety and their impact on functioning (e.g., the Penn State Worry Questionnaire; OQ-45.2; Symptom Checklist-90-R; Beck Anxiety Inventory; Hamilton Anxiety Rating Scale; or State-Trait Anxiety Inventory); evaluate the results and give feedback to him/her; readminister as needed to assess treatment response.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)

6. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated

disorders (e.g., oppositional defiant behavior with 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).

5. Cooperate with a medication evaluation. (10)

6. Report a decrease in anxiety symptoms through regular use of psychotropic medications. (11)

10. Refer the client to a physician for an evaluation as to the need for psychotropic medications.

11. Monitor the client's medication compliance, effectiveness, and side effects; reinforce consistent use of the medication; report to prescribing physician as needed.

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

12. Discuss how generalized anxiety typically involves excessive worry about unrealistic threats; various bodily expressions of tension, overarousal, and hypervigilance; and avoidance of what is threatening that interact to maintain the problem (assign "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework Planner* by Jongsma); see *Mastery of Your Anxiety and Worry—Therapist Guide* by Zinbarg, Craske, and Barlow; Treating GAD by Rygh and Sanderson.

13. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduce overarousal, and eliminate unnecessary avoidance.

14. Assign the client to read psychoeducational sections of books or treatment manuals on worry and generalized anxiety (e.g., *Mastery of Your Anxiety and Worry—Workbook* by Craske and Barlow; *Overcoming Generalized Anxiety Disorder* by White).

8. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (15, 16, 17, 18)

15. Teach the client relaxation skills (e.g., progressive muscle, guided imagery, slow diaphragmatic breathing) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life (e.g., *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens;

Treating GAD by Rygh and Sanderson).

16. Assign the client homework each session in which he/she practices relaxation exercises daily, gradually applying them progressively from non-anxiety-provoking to anxiety-provoking situations; review and reinforce success while providing corrective feedback toward improvement.

17. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *Progressive Relaxation Training* by Bernstein and Borkovec; *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske).

18. Use biofeedback techniques to facilitate the client's success at learning calming skills.

9. Learn and implement a strategy to limit the association between various environmental settings and worry, delaying the worry until a designated "worry time." (19, 20)

19. Explain the rationale for using a worry time as well as how it is to be used; agree upon a worry time with the client and implement.

20. Teach the client how to recognize, stop, and postpone worry to the agreed-upon worry time using skills such as thought-stopping, relaxation, and redirecting attention (or assign "Making Use of the Thought-Stopping Technique" and/or "Worry Time" in the *Adult Psychotherapy Homework Planner* by Jongsma to assist skill development); encourage use in daily life; review and reinforce success while providing

corrective feedback toward improvement.

10. Verbalize an understanding of the role that cognitive biases play in excessive irrational worry and persistent anxiety symptoms. (21, 22, 23)

21. Discuss examples demonstrating that unrealistic worry typically overestimates the probability of threats and underestimates or overlooks the client's ability to manage realistic demands (or assign "Past Successful Anxiety Coping" in the *Adult Psychotherapy Homework Planner* by Jongsma).

22. Assist the client in analyzing his/her worries by examining potential biases such as the probability of the negative expectation occurring, the real consequences of it occurring, his/her ability to control the outcome, the worst possible outcome, and his/her ability to accept it (see "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework Planner* by Jongsma; *Cognitive Therapy of Anxiety Disorders* by Clark and Beck).

23. Help the client gain insight into the notion that worry may function as a form of avoidance of a feared problem, creates acute and chronic tension, and precludes chances to overcome the fear.

11. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (24, 25, 26, 27)

24. Explore the client's schema and self-talk that mediate his/her fear response, and challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase his/her self-confidence in coping with irrational fears.

25. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (or assign "Negative Thoughts Trigger Negative Feelings" or "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

26. Teach the client to implement a thought-stopping technique (thinking of a stop sign and then a pleasant scene) for worries that have been addressed but persist (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); monitor and encourage the client's use of the technique in daily life between sessions.

27. Assign the client to read about cognitive restructuring of worry in relevant books or treatment manuals (e.g., *Mastery of Your Anxiety and Panic—Workbook* by Barlow and Craske).

12. Participate in gradual repeated imaginal exposure to the feared negative consequences predicted by irrational worries and develop reality-based predictions. (28, 29, 30, 31, 32)

28. Assign the client to read about worry exposure in books or treatment manuals on the treatment of worry and generalized anxiety (e.g., *Mastery of Your Anxiety and Worry—Therapist Guide* by Zinbarg, Craske, and Barlow).

29. Direct and assist the client in constructing a hierarchy of two to three spheres of worry for use in exposure (e.g., worry about harm to others, financial difficulties, relationship problems).

30. Select initial exposures that have a high likelihood of being a success experience for the client; develop a plan for managing the negative affect engendered by exposure; mentally rehearse the procedure.

31. Ask the client to vividly imagine worst-case consequences of worries, holding them in mind until anxiety associated with them weakens (up to 30 minutes); generate reality-based alternatives to that worst case and process them (e.g., *Mastery of Your Anxiety and Worry: Therapist Guide* by Zinbarg, Craske, and Barlow).

32. Assign the client a homework exercise in which he/she does worry exposures and records responses (see *Mastery of Your Anxiety and Worry: Therapist Guide* by Zinbarg, Craske, and Barlow); review, reinforce success, and provide corrective feedback toward improvement.

13. Learn and implement problem-solving strategies for realistically addressing worries. (33, 34)

33. Teach problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating options, implementing a plan, and reevaluating and refining the plan (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

34. Assign the client a homework exercise in which he/she problem-solves a current problem (see *Mastery of Your Anxiety and Worry—Workbook*

	by Craske and Barlow); review, reinforce success, and provide corrective feedback toward improvement (or assign "Applying Problem-Solving to Interpersonal Conflict" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma).
14. Identify and engage in rewarding activities on a daily basis. (35)	35. Engage the client in behavioral activation, increasing the client's contact with sources of reward, identifying processes that inhibit activation, and teaching skills to solve life problems (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, and role reversal as needed to assist adoption into the client's daily life; reinforce success.
15. Learn and implement personal and interpersonal skills to reduce anxiety and improve interpersonal relationships. (36, 37)	36. Use instruction, modeling, and role-playing to build the client's general social, communication, and/or conflict resolution skills.
	37. Assign the client a homework exercise in which he/she implements communication skills training into his/her daily life (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma); review, reinforce success, and provide corrective feedback toward improvement.

16. Learn and implement relapse prevention strategies for managing possible future anxiety symptoms. (38, 39, 40)

38. 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.

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

40. Instruct the client to routinely use new therapeutic skills such as relaxation, cognitive restructuring, exposure, and problem-solving exposures as needed to address emergent worries, building them into his/her life as much as possible.

17. Learn to accept limitations in life and commit to tolerating, rather than avoiding, unpleasant emotions while accomplishing meaningful goals. (41)

41. Use techniques from Acceptance and Commitment Therapy to help client accept uncomfortable realities such as lack of complete control, imperfections, and uncertainty and tolerate unpleasant emotions and thoughts in order to accomplish value-consistent goals.

18. Identify the fears that were learned in the family of origin, and relate these fears to current anxiety levels. (42, 43)

42. Probe the client's family-of-origin experiences for fear-producing situations; help him/her relate these past events to current anxious thoughts, feelings, and behaviors; encourage and support the client's verbal expression and clarification of his/her feelings that are associated with past rejection experiences, harsh criticism, abandonment, or trauma.

43. Assign the client to read books on resolving painful early family

experiences (e.g., *Healing the Shame That Binds You* by Bradshaw or *Facing Shame* by Fossum and Mason); process key concepts learned from the reading.

19. Write a specific plan to follow when anxious and subsequently craving substance use. (44, 45, 46)

44. Assist the client in developing a list of 10 positive statements to read to himself/herself several times per day, particularly when feeling anxious.

45. Using a 12-step program's Step 3 exercise, show the client how to turn over problems, worries, and anxieties to a higher power and to trust that the higher power is going to help him/her resolve the situation.

46. Help the client develop an alternative constructive plan of action (e.g., relaxation exercises, physical exercise, calling a sponsor, going to a meeting, calling the counselor, talking to someone) when feeling anxious and craving substance use (or assign "Coping With Stress" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

20. Write an autobiography, detailing those behaviors in the past that are related to current anxiety or guilt, and the subsequent abuse of substances as a means of escape. (47, 48)

47. Probe the client's family-of-origin experiences for fear-producing situations; help him/her relate these past events to current anxious thoughts, feelings, and behaviors.

48. Using a 12-step program's Step 4 exercise, have the client write an autobiography detailing the exact nature of his/her mistakes; teach the client how to begin to forgive himself/herself and others (or assign the client to complete

	the Step 4 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
21. Develop a program of recovery that includes regularly helping others at recovery group meetings. (49)	49. Help the client develop a structured program of recovery that includes regularly helping others at 12-step program recovery groups.
22. Family members verbalize an understanding of anxiety and addiction, and discuss the ways they and the client can facilitate the recovery process. (50, 51)	50. Provide the family members with information about anxiety and addiction and the tools that are used to assist the client in recovery. 51. Assist each family member in developing a list of three things that he/she can do to assist the client in recovery; hold a family session to facilitate communication of the actions on the list.
23. Complete a survey to assess the degree of satisfaction with treatment. (52)	52. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

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

Axis II:	301.50	Histrionic Personality Disorder
	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.00	F41.9	Unspecified Anxiety Disorder
300.02	F41.1	Generalized Anxiety Disorder
300.09	F41.8	Other Specified Anxiety Disorder
309.21	F93.0	Separation Anxiety Disorder
309.24	F43.22	Adjustment Disorder With Anxiety
301.50	F60.4	Histrionic Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder

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

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

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)—ADOLESCENT

BEHAVIORAL DEFINITIONS

1. Short attention span; difficulty sustaining attention on a consistent basis.
2. Susceptibility to distraction by extraneous stimuli and internal thoughts.
3. Gives impression that he/she is not listening well.
4. Repeated failure to follow through on instructions or complete school assignments or chores in a timely manner.
5. Poor organizational skills as demonstrated by forgetfulness, inattention to details, and losing things necessary for tasks.
6. Hyperactivity as evidenced by a high energy level, restlessness, difficulty sitting still, or loud or excessive talking.
7. Impulsivity as evidenced by difficulty awaiting turn in group situations, blurting out answers to questions before the questions have been completed, and frequent intrusions into others' personal business.
8. Frequent disruptive, aggressive, or negative attention-seeking behaviors.
9. Tendency to engage in carelessness or potentially dangerous activities.
10. Difficulty accepting responsibility for actions, projecting blame for problems onto others, and failing to learn from experience.
11. Low self-esteem and poor social skills.
12. ADHD traits increase vulnerability to addictive behaviors.

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LONG-TERM GOALS

1. Maintain a program of recovery from addiction, and reduce the negative effects of ADHD on learning, social interaction, and self-esteem.
2. Develop the coping skills necessary to improve ADHD and eliminate addiction.
3. Understand the relationship between ADHD symptoms and addiction.
4. Sustain attention and concentration for consistently longer periods of time and increase the frequency of on-task behaviors.
5. Demonstrate marked improvement in impulse control.
6. Regularly take medication as prescribed to decrease impulsivity, hyperactivity, and distractibility.
7. Parents and/or teachers successfully utilize a reward system, contingency contract, or token economy to reinforce positive behaviors and deter negative behaviors.
8. Develop positive social skills to help maintain lasting peer friendships.

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SHORT-TERM OBJECTIVES

1. Client and parents describe the nature of the ADHD including specific behaviors, triggers, and consequences. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client and parents through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's ADHD behavior; the thoughts, feelings, and actions that have characterized his/her responses; and the consequences of the behavior

	(e.g., reinforcements, punishments), toward identifying target behaviors, antecedents, consequences, and the appropriate placement of interventions (e.g., school-based, home-based, peer-based).
	3. Rule out alternative conditions/causes of inattention, hyperactivity, and impulsivity (e.g., other behavioral, physical, emotional problems, or normal developmental behavior).
2. Complete psychological testing or objective questionnaires for assessing ADHD and substance abuse and/or to rule out emotional factors or learning disabilities as the basis for maladaptive behavior. (4)	4. Administer to the client psychological instruments designed to objectively assess ADHD (e.g., the ADHD Rating Scale-IV; Substance Abuse Subtle Screening Inventory-3; the Disruptive Behavior Rating Scale); give the client feedback regarding the results of the assessment; readminister as needed to assess response to treatment.
3. Identify and monitor the symptoms of ADHD and their impact on daily living. (5)	5. Teach the client how to monitor ADHD symptoms, rate their severity on a scale (e.g., 0–10), and (if indicated) record their consequences; implement daily self-monitoring.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)	6. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance

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

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

5. Verbalize the powerlessness and unmanageability that resulted from treating ADHD symptoms with addiction. (10)

10. Using a 12-step recovery program's Step One exercise, help the client to accept his/her powerlessness and unmanageability over ADHD symptoms and addiction (or assign the client to complete the

	Step One exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
6. Verbalize the relationship between ADHD and addiction. (11)	11. Using a biopsychosocial approach, teach the client about the relationship between ADHD symptoms and the use of substances to control symptoms.
7. Implement a program of recovery structured so as to bring ADHD and addiction under control. (12)	12. Help the client to develop a program of recovery that includes the elements necessary to bring ADHD and addiction under control (e.g., medication, behavior modification, environmental controls, aftercare meetings, further therapy) (or assign "Developing a Recovery Program" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
8. List five ways a higher power can be used to assist in recovery from ADHD and addiction. (13)	13. Teach the client about the Alcoholics Anonymous concept of a higher power and how this power can assist him/her in recovery.
9. Implement remedial procedures for any learning disabilities that add to the client's frustration. (14)	14. Refer the client to an educational specialist to design remedial procedures for any learning disabilities that may be present in addition to ADHD.
10. Take prescribed medication as directed by the physician. (15, 16)	15. Arrange for a medication evaluation for the client.
	16. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals; (consider assigning "Evaluating Medication Effects" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

11. Parents and the client increase knowledge about ADHD symptoms. (17, 18, 19, 20)

17. Educate the client and/or client's parents about the signs and symptoms of ADHD.

18. Discuss with the client and/or parents the various treatment options for ADHD (e.g., behavioral parent training, classroom-based behavioral management programs, peer-based programs, medication), discussing risks and benefits to fully inform the parents' decision-making.

19. Assign the parents readings to increase their knowledge of ADHD (e.g., *Taking Charge of ADHD* by Barkley; *Parenting Children With ADHD: 10 Lessons That Medicine Cannot Teach* by Monastra; *The Family ADHD Solution: A Scientific Approach to Maximizing Your Child's Attention and Minimizing Parental Stress* by Bertin).

20. Assign the client readings to increase his/her knowledge about ADHD and ways to manage related behavior (e.g., *The ADHD Workbook for Teens: Activities to Help You Gain Motivation and Confidence* by Honos-Webb; *Take Control of ADHD: The Ultimate Guide for Teens With ADHD* by Spodak and Stephano; *ADHD—a Teenager's Guide* by Crist).

12. Parents learn and implement Parent Management Training to increase prosocial behavior and decrease disruptive behavior of their adolescent child/children. (21, 22, 23, 24, 25)

21. Explain how parent and child behavioral interactions can reduce the frequency of impulsive, disruptive, and negative attention-seeking behaviors and increase desired prosocial behavior through prompting and reinforcing

positive behaviors as well as use of clear instruction, time out, and other loss-of-privilege practices for problem behavior (recommend *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together: The Basics* by Patterson and Forgatch).

22. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior (assign "Switching From Defense to Offense" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

23. Teach parents about the possible functions of the ADHD behavior (e.g., avoidance, attention, to gain a desired object/activity, regulate sensory stimulation); how to test which function(s) is being served by the behavior; and how to use parent training methods to manage the behavior.

24. Assign the parents home exercises in which they implement and record results of reinforcing prosocial (assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback

toward improved, appropriate, and consistent use of skills.

25. Refer parents to a Parent Management Training course.

13. Parents work with therapist and school to implement a Behavioral Classroom Management program. (26, 27)

26. Consult with the client's teachers to implement age-appropriate strategies to improve school performance, such as sitting in the front row during class, using a prearranged signal to redirect the client back to task, scheduling breaks from tasks, providing frequent feedback, calling on the client often, arranging for a listening buddy, and implementing a daily behavioral report card.

27. Consult with parents and pertinent school personnel to implement an age-appropriate Behavioral Classroom Management intervention (see *ADHD in the Schools* by DuPaul and Stoner, or *Homework Success for Children with ADHD: A Family-School Intervention Program* by Power, Karustis, and Habboushe) that reinforces appropriate behavior at school and at home, uses time out for undesirable behavior, and uses a daily behavioral report card to monitor progress.

14. Complete a peer-based treatment program focused on improving social interaction skills. (28)

28. Conduct or refer the client to a Behavioral Peer Intervention (e.g., Summer Treatment Program or after school–weekend version) that involves brief social skills training followed by coached group play in recreational activities guided by contingency management systems (e.g., point system, time

out) and utilizing objective observations, frequency counts, and adult ratings of social behaviors as outcome measures (see *Children's Summer Treatment Program Manual* by Pelham, Greiner, and Gnagy).

15. Parents develop and utilize an organized system to keep track of the client's school assignments, chores, and household responsibilities. (29)

29. Assist the parents in developing and implementing an organizational system to increase the client's on-task behaviors and completion of school assignments, chores, or household responsibilities through the use of calendars, charts, notebooks, and class syllabi (see "Getting It Done" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

16. Increase frequency of completion of school assignments, chores, and household responsibilities. (30, 31, 32)

30. Assist the parents in developing a routine schedule to increase the client's compliance with school, household, or work-related responsibilities.

31. Consult with the client's teachers to implement strategies to improve school performance (e.g., sitting in the front row during class, using a prearranged signal to redirect the client back to task, scheduling breaks from tasks, providing frequent feedback, calling on the client often, arranging for a listening buddy).

32. Encourage the parents and teachers to utilize a school contract and reward system to reinforce completion of the client's assignments (or employ the "Getting It Done" program in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Implement effective test-taking strategies on a consistent basis to improve academic performance. (33)

33. Teach the client more effective test-taking strategies (e.g., reviewing material regularly, reading directions twice, rechecking work).

18. Delay instant gratification in favor of achieving meaningful long-term goals. (34, 35)

34. Teach the client mediational 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, long-term goals.

35. Assist the parents in increasing structure to help the client learn to delay gratification for longer term goals (e.g., completing homework or chores before playing basketball).

19. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (36, 37, 38)

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

37. Work with the parents and assign exercises that facilitate the client's use of social skills in various everyday situations.

38. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner) or assign the "Social Skills Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis.

20. Identify and implement effective problem-solving strategies. (39, 40)

39. Teach the client effective problem-solving skills (e.g., identifying the problem, brainstorming alternative solutions, selecting an option,

implementing a course of action, and evaluating the results).

40. Utilize role-playing and modeling to teach the client how to implement effective problem-solving techniques in his/her daily life; work with the parents and assign exercises that facilitate the client's use of problem-solving in various everyday situations; (assign the "Stop, Think, and Act" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Learn and implement constructive coping strategies to use when the negative emotions associated with failure are a trigger for addiction. (41, 42)

41. Review specific instances of failure to learn and the negative emotions associated with the experience; focus on how addictive behavior was used to escape from negative emotions.

42. Role-play and model constructive alternative coping behaviors to use in failure-to-learn situations (e.g., cognitive focusing, deep breathing, make lists, reduce distractions, shorten learning sessions, repeat instructions verbally).

22. Report instances when relaxation techniques reduced tension and frustration while increasing focus in a learning situation. (43, 44)

43. Using techniques like progressive relaxation, guided imagery, or biofeedback, teach the client how to relax completely; assign him/her to relax twice per day for 10 to 20 minutes per session.

44. Encourage the client to implement relaxation skills as a coping and focusing mechanism when feeling tense and frustrated by a learning situation; review implementation; reinforce success and problem-solve obstacles.

23. Develop and implement an exercise program that includes exercising at a training heart rate for at least 20 minutes at least three times per week. (45)

24. Develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addiction under control. (46)

25. Complete a survey to assess the degree of satisfaction with treatment. (47)

45. Help the client develop an exercise program; increase the exercise by 10% each week until the client is exercising at a training heart rate for at least 20 minutes, at least three times a week.

46. Help the client to develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addictive behavior under control.

47. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	312.81	Conduct Disorder, Childhood-Onset Type
	312.82	Conduct Disorder, Adolescent-Onset Type
	313.81	Oppositional Defiant Disorder

	312.9	Disruptive Behavior Disorder NOS
	296.xx	Bipolar I Disorder
	_____	_____
	_____	_____
Axis II:	V71.09	No Diagnosis
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
314.01	F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Presentation
314.00	F90.0	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
314.01	F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder
314.01	F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.82	F91.2	Conduct Disorder, Adolescent-Onset Type
313.81	F91.3	Oppositional Defiant Disorder
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
296.xx	F31.xx	Bipolar I Disorder

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

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

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)—ADULT

BEHAVIORAL DEFINITIONS

1. Demonstrates a pattern of restlessness and hyperactivity leading to attention deficits or learning disability.
2. Demonstrates inability to sustain attention long enough to learn normally at work or school.
3. Fails to give sufficient attention to detail and tends to make careless mistakes.
4. Does not complete tasks or takes a longer than necessary amount of time to complete tasks.
5. ADHD/ADD (attention deficit disorder) symptoms and the frustration associated with them increase vulnerability to addictive behavior.
6. Often does not follow through on instructions, procrastinates, and fails to finish tasks.
7. Becomes too easily distracted by extraneous stimulation.
8. Exhibits difficulty organizing events, material, or time.
9. Is easily overwhelmed with tasks that require attention to many details.
10. Shows poor planning and organizational skills.
11. Often loses or misplaces items.
12. Intrudes on conversations or talks excessively.
13. Acts too quickly on feelings without thought or deliberation.

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LONG-TERM GOALS

1. Maintain a program of recovery from addiction and reduce the negative effects of ADHD on learning, social interaction, and self-esteem.
2. Develop the coping skills necessary to improve ADHD and eliminate addiction.
3. Understand the relationship between ADHD symptoms and addiction.
4. Develop the skills necessary to bring ADHD symptoms under control so normal learning can take place.
5. Decrease impulsivity by learning how to stop, think, and plan before acting.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe past and present experiences with ADHD, including its effects on functioning. (1, 2)	1. Establish rapport with the client toward building a therapeutic alliance. 2. Conduct a thorough psychosocial assessment including past and present symptoms of ADHD and their effects on educational, occupational, and social functioning.
2. Complete psychological testing or objective questionnaires for assessing ADHD and substance abuse. (3)	3. Administer to the client psychological instruments designed to objectively assess ADHD (e.g., Conners Adult ADHD Rating Scales, Substance Abuse Subtle Screening Inventory-3); give the client feedback regarding the results of the assessment; readminister

	as needed to assess response to treatment.
3. Complete psychological testing to rule out emotional factors or learning disabilities as the basis for maladaptive behavior. (4, 5)	4. Arrange for psychological testing to rule out emotional factors or learning disabilities as the basis for the client's maladaptive behavior.
	5. Give feedback to the client and his/her family regarding psychological testing results.
4. Identify the symptoms of ADHD and their impact on daily living. (6)	6. Explore the client's pattern of ADHD symptoms and their impact on his/her daily functioning.
5. Identify the current, specific ADHD behaviors that cause the most difficulty. (7, 8, 9)	7. Assist the client in identifying the current, specific ADHD behaviors that cause him/her the most difficulty functioning as part of identifying treatment targets (i.e., a functional analysis).
	8. Review the results of psychological testing and/or psychiatric evaluation again with the client, assisting in identifying or in affirming his/her choice of the most problematic behavior(s) to address.
	9. Ask the client to have extended family members and close collaterals complete a ranking of the behaviors they see as interfering the most with his/her daily functioning (e.g., mood swings, temper outbursts, easily stressed, short attention span, never completes projects).
6. List the negative consequences of the ADHD problematic behavior. (10)	10. Assign the client to make a list of negative consequences of ADHD that he/she has experienced or that could result from a continuation of the problematic

behavior; process the list (or assign "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).

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)

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).
8. Verbalize the powerlessness and unmanageability that resulted from treating ADHD symptoms with addiction. (15)	15. Using a 12-step recovery program's Step 1 exercise, help the client to accept his/her powerlessness and unmanageability over ADHD symptoms and addiction (or assign the client to complete the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
9. Verbalize the relationship between ADHD and addiction. (16)	16. Using a biopsychosocial approach, teach the client about the relationship between ADHD symptoms and the use of substances to control symptoms.
10. Implement a program of recovery structured so as to bring ADHD and addiction under control. (17)	17. Help the client to develop a program of recovery that includes the elements necessary to bring ADHD and addiction under control (e.g., medication, behavior modification, environmental controls, aftercare meetings, further therapy) (or assign the client to complete the "Mastering Your Adult ADHD" exercise in *Mastery of Your Adult ADHD—Client Workbook* by Safren, Spirch, Perlman, and Otto).
11. List five ways a higher power can be used to assist in recovery from ADHD and addiction. (18)	18. Teach the client about the Alcoholics Anonymous concept of a higher power and how this power can assist him/her in recovery.

12. Implement remedial procedures for any learning disabilities that add to the client's frustration. (19)

13. Take prescribed medication as directed by the physician. (20, 21)

14. Increase knowledge about ADHD symptoms and their treatment. (22, 23, 24)

15. Read self-help books about ADHD to improve understanding of the condition and its features. (25, 26)

19. Refer the client to an educational specialist to design remedial procedures for any learning disabilities that may be present in addition to ADHD.

20. Arrange for a medication evaluation for the client.

21. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals.

22. Educate the client about the signs and symptoms of ADHD and how they disrupt functioning through the influence of distractibility, poor planning and organization, maladaptive thinking, frustration, impulsivity, and possible procrastination (or assign "Symptoms and Fixes for ADD" in the *Adult Psychotherapy Homework Planner* by Jongsma).

23. Discuss a rationale for treatment that accordingly targets improvement in organizational and planning skills, management of distractibility, cognitive restructuring, and overcoming procrastination (see *Mastery of Your Adult ADHD—Therapist Guide* by Safren, Spirch, Perlman, and Otto).

24. Teach the client how to monitor ADHD symptoms and assign monitoring tasks selectively for use in therapy.

25. Assign the client readings consistent with the treatment model to increase his/her knowledge of ADHD and its

treatment (e.g., *Mastery of Your Adult ADHD—Client Workbook* by Safren et al.).

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

16. Invite a significant other to join in the therapy to provide support throughout therapy. (27)

27. 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.

17. Learn and implement organization and time management skills. (28, 29, 30, 31)

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

29. Develop with the client a procedure for classifying and managing mail and other papers as well as scheduled appointments.

30. Teach the client problem-solving skills as an approach to planning; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility (or assign "Getting Organized" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

31. Assign homework (e.g., "Problem-Solving: An

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

18. Learn and implement skills to reduce the disruptive influence of distractibility. (32, 33, 34, 35)

32. Assess the client's typical attention span by having him/her do a few boring tasks (e.g., sorting bills, reading something uninteresting) to the point that he/she reports distraction; use this as an approximate measure of his/her typical attention span.

33. Teach the client stimulus control techniques that use external structure (e.g., lists, reminders, files, daily rituals) to improve on-task behavior; remove distracting stimuli in the environment; encourage the client to reward himself/herself for successful focus and follow-through.

34. Teach the client to break down tasks into meaningful smaller units that can be completed without being distracted based on his/her demonstrated attention span.

35. Teach the client to use timers or other cues to remind him/her to stop a task before he/she gets distracted in an effort to reduce the time he/she may be distracted and off-task (see *Mastery of Your Adult ADHD—Therapist Guide* by Safren et al.).

19. Identify, challenge, and change self-talk that contributes to maladaptive feelings and actions. (36, 37)

36. Use cognitive therapy techniques to help the client identify maladaptive self-talk (e.g., that causing frustration, impulsivity, self-deprecation); challenge biases; and generate alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma).

37. Assign homework asking the client to implement cognitive restructuring skills in relevant tasks; review and provide corrective feedback toward improving the skills.

20. Acknowledge procrastination and the need to reduce it. (38)

38. Assist the client in identifying positives and negatives of procrastinating toward the goal of engaging him/her in staying focused.

21. Learn and implement skills to reduce procrastination. (39, 40, 41, 42)

39. Teach the client to apply 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.

40. 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.

41. Assign homework asking the client to accomplish identified tasks without procrastination using the techniques learned in therapy; review and provide

corrective feedback toward improving the skill and decreasing procrastination.

42. Assist the client in developing calendars or lists to record the details of scheduled activities and obligations; ask him/her to keep the list with him/her always and mark off each item as it is completed.

22. Create and utilize an environment free from distracting stimuli that can be used for productive learning. (43)

43. Help the client design and implement an environment that is free of extraneous stimulation and can be used as a place of study, concentration, and learning.

23. Combine skills learned in therapy into a new daily approach to managing ADHD. (44, 45, 46)

44. Teach the client mediational 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 (or assign "From Recklessness to Calculated Risks" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

45. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing ADHD, starting with situations in which the client is highly likely to be successful (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma).

46. Use any of several techniques, including imagery, behavioral rehearsal, modeling, role-playing, or in vivo exposure/ behavioral experiments to help

the client consolidate the use of his/her new ADHD management skills.

24. Implement less impulsive social skills to minimize intrusions and offending others. (47, 48, 49, 50)

47. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills (see *What Does Everybody Else Know That I Don't? Social Skills Help for Adults with Attention Deficit/Hyperactivity Disorder* by Novotni and Peterson).

48. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

49. Review social situations in which the client was intrusive or talked excessively without thoughtfulness; redirect for more social success using modeling, role-playing, and instruction.

50. Teach the client problem-solving techniques that require thought before taking action to apply to interpersonal conflict situations (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma or "Staying Attentive and Other Negotiating Skills" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

25. Learn and implement calming skills to reduce impulsivity. (51)

51. Teach the client deep muscle and deep breathing relaxation skills; use modeling and behavior rehearsal to apply these skills to

	decrease impulsive actions and reduce tension (or assign "Self-Soothing: Calm Down, Slow Down" in the *Addiction Treatment Homework Planner* by Finley and Lenz). EB
26. Develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addiction under control. (52)	52. Help the client to develop an aftercare program that includes regular attendance at recovery group meetings, getting a sponsor, and continuing the therapy necessary to bring ADHD and addictive behavior under control.
27. Complete a survey to assess the degree of satisfaction with treatment. (53)	53. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	296.xx	Bipolar I Disorder
	301.13	Cyclothymic Disorder
	296.90	Mood Disorder NOS
	312.30	Impulse-Control Disorder NOS
	_____	_____
	_____	_____

Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
314.00	F90.0	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
314.01	F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder
314.01	F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder
296.xx	F31.xx	Bipolar I Disorder
301.13	F34.0	Cyclothymic Disorder
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder

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

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

BIPOLAR DISORDER

BEHAVIORAL DEFINITIONS

1. History of at least one hypomanic, manic, or mixed mood episode.
2. Has an inflated sense of self-esteem and an exaggerated, euphoric belief in capabilities that denies any self-limitations or realistic obstacles, but sees others as standing in the way.
3. Is more talkative than normal—pressured speech.
4. Experiences racing thoughts—flight of ideas.
5. Is easily distracted by unimportant stimuli.
6. Has increased level of energy that is rigidly goal-directed but not efficient.
7. Engages in impulsive activities that are potentially self-damaging (e.g., buying sprees, sexual acting out, foolish business investments).
8. Impulsively uses drugs or alcohol without regard to the negative consequences.
9. History of depressed or irritable mood episodes.
10. Decrease or increase in appetite.
11. Diminished interest in or enjoyment of activities.
12. Psychomotor agitation or retardation.
13. Sleeplessness or hypersomnia.
14. Lack of energy; fatigue.
15. Poor concentration and indecisiveness.
16. Social withdrawal and lack of interest in activities.
17. Suicidal thoughts and/or gestures.
18. Feelings of hopelessness, worthlessness, or inappropriate guilt.
19. Frequent thoughts of death or suicide.
20. Mood can cycle from depressed to manic (or vice versa) unpredictably.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of bipolar behavior and addiction.
2. Alleviate mood symptoms and return to previous level of effective functioning.
3. Understand the biopsychosocial aspects of bipolar disorder and addiction, and accept the need for continued treatment, including medication.
4. Understand the relationship between mood episodes and addiction.
5. Develop a healthy, rewarding, day-to-day pattern of activities and sleep that leads to the alleviation of, and helps prevent the relapse of, mood episodes.
6. Normalize energy level and return to usual activities, good judgment, stable mood, more realistic expectations, and goal-directed behavior.
7. Achieve controlled behavior, moderated mood, more deliberative speech and thought process, and a stable daily activity pattern.

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SHORT-TERM OBJECTIVES

1. Describe the personal history of mood changes and associated changes in behavior, outlook, and interpersonal relationships; allow significant others to participate in this discussion. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings, express empathy, and build rapport while assessing primary cognitive, behavioral, interpersonal, or other symptoms of the mood disorder.
2. Conduct a thorough assessment including the presence, severity, and impact of past and present mood episodes including manic,

	hypomanic, mixed, and depressed on social, occupational, personal, and interpersonal functioning; supplement with information from third parties; use semi-structured inventory as a guide, if desired (e.g., Young Mania Rating Scale); readminister as needed to assess treatment response.
2. Verbalize an acceptance of the sense of powerlessness and unmanageability that results from mania/hypomania and using addiction to cope with impulsivity and mood swings. (3)	3. Using a 12-step recovery program's Step 1 exercise, help the client to see the powerlessness and unmanageability that result from mania/hypomania and the use of addictive behavior to cope with these symptoms.
3. Identify manic behavior patterns and list several specific instances in which manic/hypomanic states led to addiction. (4, 5)	4. Teach the client about the signs and symptoms of mania/hypomania and how it can foster addictive behavior (or assign "Early Warning Signs of Mania/Hypomania" in the *Addiction Treatment Homework Planner* by Finley and Lenz). 5. Assess the client's addictive behavior history, and identify instances in which manic/hypomanic states led to addictive behavior (or assign "Mania, Addiction, and Recovery" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
4. Complete psychological testing or objective questionnaires for assessing mania/hypomania. (6)	6. Administer to the client psychological instruments designed to objectively assess features related to Bipolar Disorder (e.g., the Clinical Monitoring Form; Beck Depression Inventory—II and/or Beck Hopelessness Scale;

Perceived Criticism Measure); give the client feedback regarding the results of the assessment; readminister as needed to assess treatment response.

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. Turn over at least one problem to a higher power each day. (11, 12, 13)	11. Teach the client about the 12-step recovery program's concept of a higher power, and how a higher power can help restore him/her to sanity (e.g., attend worship services and practice daily prayer and meditation).
	12. Using a 12-step recovery program's Step 3 exercise, teach the client how to turn problems over to a higher power.
	13. Assign the client to turn over one problem each day to a higher power; review the client's implementation, reinforcing success and redirecting for failure.
7. Cooperate with a medical/psychiatric evaluation for medication needs and possible hospitalization to stabilize symptoms. (14, 15)	14. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her own basic needs, or symptom severity warrants it.
	15. Arrange for a medication evaluation with a psychiatrist to determine appropriate pharmacotherapy (e.g., Lithium Carbonate, Depakote, Lamictal, Abilify, etc.).
8. Take prescribed medications as directed. (16, 17)	16. Monitor the client for use and effectiveness of psychotropic

	medication (e.g., compliance, side effects, and effectiveness).
	17. Continually evaluate the client's compliance with the psychotropic medication prescription.
9. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (18)	18. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in individual or group psychotherapy.
10. Verbalize an understanding of the causes for, symptoms of, and treatment of manic, hypomanic, mixed, and/or depressive episodes. (19, 20, 21)	19. Provide psychoeducation, 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).
	20. Teach a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to stresses that are manageable and the need for medication compliance.
	21. Provide a rationale for treatment involving ongoing medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse.
11. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (22, 23, 24)	22. Use motivational approaches (e.g., *Motivational Interviewing* by Miller and Rollnick) to enhance engagement in medication use and compliance.
	23. Educate the client about the importance of medication compliance; teach him/her the

risk for relapse when medication is discontinued, and work toward a commitment to prescription adherence.

24. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance; develop a plan for recognizing and addressing them (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma).

12. Attend group psychoeducational sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (25, 26)

25. Conduct or refer the client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in the development of bipolar disorder and its biological and psychological treatment (see *Structured Group Psychotherapy for Bipolar Disorder: The Life Goals Program* by Bauer and McBride; *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta).

26. Teach the group members illness management skills (e.g., early warning signs, common triggers, coping strategies), problem-solving focused on life goals, and a personal care plan that emphasizes a regular sleep routine, the need to comply with medication, and ways to minimize relapse through stress regulation.

13. Identify and replace thoughts and behaviors that trigger manic or depressive symptoms. (27, 28)

27. Use cognitive therapy techniques to explore and educate the client about cognitive biases that trigger his/her elevated or depressive mood (see *Cognitive*

	Therapy for Bipolar Disorder by Lam, Jones, and Hayward).
	28. Assign the client a homework exercise in which he/she identifies self-talk reflective of mania, biases in the self-talk, and alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.
14. Implement a comprehensive cognitive-behavioral program designed to control mood swings, decrease impulsivity, and prevent relapse. (29)	29. 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, Jones, and Hayward).
15. Client and family members verbalize an understanding of bipolar disorder, factors that influence it, and the role of medication and therapy. (30, 31)	30. 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).

31. 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.

16. Client and family members implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (32, 33, 34, 35)

32. Use 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.

33. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.

34. Use 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.

35. 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 assign "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session.

17. Develop a relapse drill in which roles, responsibilities, and a course of action are agreed upon in the event that signs of relapse emerge. (36)

36. 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.

18. Maintain a pattern of regular rhythm to daily activities. (37, 38, 39, 40)

37. 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: A Clinician's Guide to Interpersonal and Social Rhythm Therapy* by Frank).

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

39. Teach the client about the importance of good sleep hygiene (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework*

Planner by Jongsma); assess and intervene accordingly (see the "Sleep Disturbance" chapter in this *Planner*).

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

19. Discuss and resolve troubling personal and interpersonal issues. (41, 42, 43)

41. 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.

42. 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.

43. 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.

20. Participate in periodic maintenance sessions. (44)

44. Hold periodic maintenance sessions within the first few months after therapy to facilitate the client's positive changes; problem-solve obstacles to improvement.

21. Increase understanding of bipolar illness by reading a book on the disorder. (45)

45. Ask the client to read a book on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder Survival Guide* by Miklowitz; *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping With Symptoms, and More* by White and Preston); review and process concepts learned through the reading.

22. Develop a personal recovery plan that includes all of the elements necessary to control mania/hypomania and to recover from addiction. (46, 47)

46. Outline with the client the essential components for managing manic/hypomanic states and addiction such as taking medication, complying with medical monitoring, continuing therapy, attending recovery groups regularly, using a higher power, getting a sponsor, and helping others in recovery (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

47. Help the client to decide what environment he/she needs in early recovery to stabilize mood and maintain abstinence.

23. Write a 12-step program's Step 4 inventory, and share with someone in recovery. (48)

48. Using a 12-step recovery program's Step 4 inventory, assign the client to write an autobiography and then share it with someone in recovery.

24. Verbalize the importance of consistently attending recovery groups and of helping others in recovery. (49, 50)

49. Teach the client the importance of working a program of recovery that includes attending recovery group meetings regularly and helping others.

50. Arrange for the client to meet a 12-step program contact person, and assign him/her to talk about manic/hypomanic states and addictive behavior.

25. Complete a survey to assess the degree of satisfaction with treatment. (51)

51. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	295.70	Schizoaffective Disorder
	296.80	Bipolar Disorder NOS
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F31.xx	Bipolar I Disorder, Manic
296.89	F31.81	Bipolar II Disorder
301.13	F34.0	Cyclothymic Disorder
295.70	F25.0	Schizoaffective Disorder, Bipolar Type

295.70	F25.1	Schizoaffective Disorder, Depressive Type
296.80	F31.9	Unspecified Bipolar and Related Disorder

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

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

BORDERLINE TRAITS

BEHAVIORAL DEFINITIONS

1. Demonstrates extreme emotional reactivity (e.g., anger, anxiety, or depression) under minor stress, which usually does not last beyond a few hours to a few days.
2. Exhibits a pattern of intense, chaotic interpersonal relationships.
3. Presents with marked identity disturbance.
4. Experiences impulsive behaviors that are potentially self-damaging.
5. Reports recurrent suicidal gestures, threats, or self-mutilating behavior.
6. Verbalizes chronic feelings of emptiness or boredom.
7. Demonstrates frequent eruptions of intense, inappropriate anger.
8. Reports feeling that others are treating him/her unfairly or that they cannot be trusted.
9. Analyzes most issues in simple terms of right and wrong (black/white, trustworthy/deceitful) without regard for extenuating circumstances or complex situations.
10. Becomes very anxious with any hint of perceived abandonment in a relationship.

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LONG-TERM GOALS

1. Develop a program of recovery from addiction that reduces the impact of borderline traits on abstinence.

2. Develop and demonstrate coping skills to reduce mood swings and control impulses.
3. Understand how borderline traits can foster a pattern of continued addictive behavior.
4. Reduce the frequency of self-damaging behaviors (e.g., substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors).
5. Terminate dichotomous thinking, unmanaged anger, and/or fear of abandonment.
6. Develop healthy and rewarding interpersonal relationships.

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SHORT-TERM OBJECTIVES

1. Discuss openly the history of difficulties that have led to seeking treatment. (1, 2, 3)

2. Complete psychological testing or objective questionnaires for

THERAPEUTIC INTERVENTIONS

1. Assess the client's experiences of distress and disability, identifying behaviors (e.g., parasuicidal acts, angry outbursts, overattachment), affect (e.g., mood swings, emotional overreactions, painful emptiness), and cognitions (e.g., biases such as dichotomous thinking, overgeneralization, catastrophizing) that will become the targets of therapy.
2. Explore the client's history of abuse and/or abandonment, particularly in childhood years.
3. Validate the client's distress and difficulties as understandable given his/her particular circumstances, thoughts, and feelings.
4. Administer to the client psychological instruments

assessing symptoms associated with borderline personality. (4)

designed to objectively assess depression, suicidality, impulsivity, and/or aggression (e.g., Millon Clinical Multiaxial Inventory-III, Hamilton Depression Rating Scale, Beck Scale for Suicide Ideation, Aggressive Acts Questionnaire, Barratt Impulsiveness Scale—11); give the client feedback regarding the results of the assessment.

3. Keep a daily record of negative emotions, thoughts, and behaviors. (5, 6)

5. Assign the client to write a daily journal of emotions that he/she experienced, thoughts attached to them, and what actions resulted from those feelings for use throughout therapy.

6. Assist the client in identifying borderline traits in his/her experience and how they have made recovery from addictive behavior more difficult.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

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).
5. Verbalize reasons why borderline traits make recovery from addictive behavior more difficult. (11)	11. Help the client to see how poor impulse control, poor anger management, fear of abandonment, and intense mood swings increase the probability of addictive behavior (or assign "Analyzing Acting-Out Behavior" in the *Addiction Treatment Homework Planner* by Finley and Lenz); explore instances when his/her borderline traits led to addictive behavior.

6. Verbalize an accurate and reasonable understanding of the process of therapy and what the therapeutic goals are. (12, 13)

7. Verbalize a decision to work collaboratively with the therapist toward the therapeutic goals. (14)

8. Verbalize any history of self-mutilative and suicidal urges and behavior. (15, 16, 17, 18)

9. Promise to contact the therapist or helpline if experiencing a

12. Orient the client to Dialectical Behavior Therapy (DBT), highlighting its multiple facets (e.g., support, collaboration, challenge, problem-solving, skill-building), and discuss dialectical/biosocial views of borderline personality emphasizing constitutional and social influences on its features (see *Doing Dialectical Behavior Therapy* by Koerner).

13. Throughout therapy, ask the client to read selected sections of books or manuals that reinforce therapeutic interventions (e.g., *Skills Training Manual for Treating BPD* by Linehan).

14. Solicit from the client an agreement to work collaboratively within the parameters of the DBT approach to overcome the behaviors, emotions, and cognitions that have been identified as causing problems in his/her life.

15. Probe the nature and history of the client's self-mutilating behavior.

16. Assess the client's suicidal gestures as to triggers, frequency, seriousness, secondary gain, and onset.

17. Arrange for hospitalization, as necessary, when the client is judged to be harmful to self.

18. Provide the client with an emergency helpline telephone number that is available 24 hours a day.

19. Interpret the client's self-mutilation as an expression of

strong urge to engage in self-harm behavior. (19, 20)

the rage and helplessness that could not be expressed as a child victim of emotional abandonment or abuse; express the expectation that the client will control the urge for self-mutilation.

20. Elicit a promise (as part of a self-mutilation and suicide prevention contract) from the client that he/she will initiate contact with the therapist or a helpline if a suicidal urge becomes strong and before any self-injurious behavior occurs; throughout the therapy process consistently assess the strength of the client's suicide potential.

10. Reduce actions that interfere with participating in therapy. (21)

21. Continuously monitor, confront, and problem-solve client actions that threaten to interfere with the continuation of therapy such as missing appointments, noncompliance, and/or abruptly leaving therapy.

11. Cooperate with an evaluation by a physician for psychotropic medication. (22, 23)

22. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for a prescription, if appropriate.

23. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.

12. Reduce the frequency of maladaptive behaviors, thoughts, and feelings that interfere with attaining a reasonable quality of life. (24)

24. Use validation, dialectical strategies (e.g., metaphor, devil's advocate) and problem-solving strategies (e.g., behavioral and solution analysis, cognitive restructuring, skills training, exposure) (or assign "Plan Before Acting" in the *Adult*

	Psychotherapy Homework Planner by Jongsma) to help the client manage, reduce, or stabilize maladaptive behaviors (e.g., angry outbursts, binge drinking, abusive relationships, high-risk sex, uncontrolled spending, etc.), thoughts (e.g., all-or-nothing thinking, catastrophizing, personalizing), and feelings (e.g., rage, hopelessness, abandonment) (see *Cognitive-Behavioral Treatment of Borderline Personality* by Linehan). EBP
EBP 13. Participate in a group (preferably) or individual personal skills development course. (25, 26)	25. Conduct group or individual skills training tailored to the client's identified problematic behavioral patterns with an emphasis on emotional regulation, distress tolerance, interpersonal effectiveness, and mindfulness. EBP
	26. Use behavioral strategies (e.g., instruction, modeling, advising) to teach social and emotional regulation skills, strengthen them (e.g., through role-playing, exposure exercises), and facilitate incorporation into the client's everyday life (e.g., assign "Forming Stable Relationships" in the *Addiction Treatment Homework Planner* by Finley and Lenz). EBP
EBP 14. Verbalize a decreased emotional response to previous or current posttraumatic stress. (27)	27. After adaptive behavioral patterns and emotional regulation skills are evident, work with the client on remembering the facts of previous trauma, reducing avoidance or denial, increasing insight into its effects, reducing maladaptive emotional and/or

behavioral responses to trauma-related stimuli, reducing self-blame, and increasing acceptance.

15. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (28, 29, 30)

28. Explore the client's schema and self-talk that mediate his/her trauma-related and other fears; identify balancing validation with change; assist him/her in generating alternatives that correct for the negative biases and build self-esteem and confidence (see *Doing Dialectical Behavior Therapy* by Koerner).

29. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma or "Automatic Thought Record" in *Overcoming Depression: A Cognitive Therapy Approach—Workbook* by Gilson, Freeman, Yates, and Freeman).

30. Reinforce the client's positive, reality-based cognitive messages that enhance self-esteem, confidence, and increase adaptive action.

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. (31, 32, 33)

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

32. Direct imaginal exposure to the trauma in session by having the client describe a chosen traumatic experience at an increasing, but client-chosen,

level of detail; integrate cognitive restructuring and repeat until associated anxiety reduces and stabilizes; record the session and have the client listen to it between sessions (see "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma and *Doing Dialectical Behavior Therapy* by Koerner); review and reinforce progress; problem-solve obstacles.

33. Assign the client a homework exercise in which he/she does an exposure exercise and records responses or listens to a recording of an in-session exposure (see *Dialectical Behavior Therapy in Clinical Practice* by Linehan, Dimeff, and Koerner); review and reinforce progress, problem-solve obstacles.

17. Verbalize a sense of self-respect that is not dependent on others' opinions. (34)

34. Help the client to value, believe, and trust in his/her evaluations of himself/herself, others, and situations and to examine them nondefensively and independent of others' opinions in a manner that builds self-reliance but does not isolate the client from others.

18. Engage in practices that help enhance a sustained sense of joy. (35)

35. Facilitate the client's personal growth by helping him/her choose experiences that strengthen self-awareness, personal values, and appreciation of life (e.g., insight-oriented therapy, spiritual practices, or other relevant life experiences) (or assign the client to complete the "Self-Soothing: Calm Down, Slow Down"

exercise from the *Addiction Treatment Homework Planner* by Finley and Lenz).

19. Learn and apply problem-solving skills to conflicts in daily life. (36)

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

20. Verbalize an understanding of how dichotomous thinking leads to interpersonal difficulties. (37, 38, 39)

37. Teach the client how dichotomous thinking leads to feelings of interpersonal distrust.

38. Challenge the extremes of the client's thinking as it relates to decisions about good or bad, or trustworthy or deceitful people.

39. Assist the client in realistically reviewing the strengths and weaknesses of his/her friends and family members (or assign "Seeing That We're All Just Human" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

21. Verbalize feelings of self-acceptance and self-confidence. (40)

40. Assist the client in resolving feelings of rejection from childhood in order to decrease his/her current feelings of vulnerability.

22. Verbalize ways in which a higher power can assist in resolving dependency needs. (41)

41. Teach the client about the higher power concept in 12-step recovery programs, and give

	examples of how he/she can turn problems over to the higher power while in recovery.
23. Exercise at least three times per week for at least 20 minutes. (42)	42. Help the client to develop an exercise program that will aid in reducing his/her stress level.
24. Write an aftercare program that lists resources that will be used when feeling angry, anxious, abandoned, or depressed, rather than reverting to addictive behavior. (43)	43. Assist the client in developing a structured aftercare program that lists resources he/she can use when feeling angry, anxious, abandoned, or depressed (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
25. Family members verbalize what each can do to assist the client in recovery. (44, 45)	44. In a family session, review what each member can do to assist the client in recovery. 45. Provide the family members with information about borderline syndrome and the steps that the client must take to recover successfully.
26. Develop a written 5-year continuing care plan to treat addiction and borderline traits. (46)	46. Assist the client in developing a 5-year continuing care plan to treat borderline traits and addiction.
27. Complete a survey to assess the degree of client's satisfaction with treatment. (47)	47. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Major Depressive Disorder
	300.4	Dysthymic Disorder
	V61.10	Partner Relational Problem
	V62.81	Relational Problem NOS
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Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
V61.10	Z63.0	Relationship Distress With Spouse or Intimate Partner
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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

CHILDHOOD TRAUMA

BEHAVIORAL DEFINITIONS

1. Reports a history of childhood physical, sexual, or emotional abuse.
2. Uses addiction behaviors to escape emotional pain tied to childhood abuse.
3. Unresolved psychological conflicts caused by childhood abuse or neglect.
4. Experiences irrational fears, suppressed rage, low self-esteem, identity conflicts, depression, or anxious insecurity related to painful early life experiences.
5. Verbalizes intrusive memories, guilt, or emotional numbing from early childhood trauma.
6. Has unresolved emotions and maladaptive behavior that is the result of childhood trauma.
7. Demonstrates inability to trust others, bond in relationships, communicate effectively, and maintain healthy interpersonal relationships because of early childhood neglect or abuse.

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LONG-TERM GOALS

1. Resolve conflicting feelings that are associated with childhood traumas and terminate addiction, which has been used as a means of coping with those unresolved feelings.
2. Develop an awareness of how childhood issues have affected addiction.

3. Learn how childhood trauma resulted in interpersonal problems and addiction.
4. Maintain a program of recovery free of addiction and the negative effects of childhood trauma.
5. Learn to forgive perpetrators and turn them over to a higher power.
6. Resolve past childhood/family issues, leading to less fear, anger, and depression, and to greater self-esteem and confidence.

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SHORT-TERM OBJECTIVES

1. Verbalize powerlessness and unmanageability experienced as a child and directly relate these feelings to addiction. (1)

2. Describe the traumatic experiences that were endured as a child, and the feelings of helplessness, rage, hurt, and sadness that resulted from those experiences. (2)

3. Complete psychological testing or objective questionnaires for assessing childhood trauma. (3)

THERAPEUTIC INTERVENTIONS

1. Using an Alcoholics Anonymous Step 1 exercise, help the client to see the powerlessness and unmanageability that resulted from using addiction to deal with negative feelings associated with childhood trauma (or assign the client to complete the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Explore the painful experiences endured in the client's family of origin, and help identify the unhealthy emotional and behavioral patterns that evolved from those experiences.

3. Administer to the client psychological instruments designed to objectively assess childhood trauma (e.g., Childhood Trauma Questionnaire, Davidson Trauma Scale, Beck Depression

	Inventory—II, Beck Anxiety Inventory); give the client feedback regarding the results of the assessment; readminister as needed to assess treatment response.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)	4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change). 5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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). 6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior. 7. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Identify feelings associated with major traumatic incidents in childhood and with parental child-rearing patterns. (8, 9, 10)	8. Support and encourage the client when he/she begins to express feelings of rage, sadness, fear, and rejection relating to family abuse or neglect.
	9. Assign the client to record feelings in a journal that describe memories, behavior, and emotions tied to his/her traumatic childhood experiences (or assign "How the Trauma Affects Me" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	10. 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.
6. Identify the unhealthy rules and roles learned in the family of origin. (11)	11. Teach the client about the unhealthy rules and roles that develop in dysfunctional families and help identify what role he/she played in the family dynamics (or assign "Changing from Victim to Survivor" in the

	Adult Psychotherapy Homework Planner by Jongsma).
7. Verbalize an understanding of how childhood abandonment, neglect, or abuse led to emotional and social problems. (12)	12. Help the client to understand the relationship between childhood trauma and current problems with trust, anger, self-esteem, or depression.
8. Identify a pattern of abusing substances as a means of escape from psychological pain associated with childhood traumas, and verbalize more constructive means of coping. (13, 14)	13. Explore the client's behavior of addiction as a means of coping with emotional pain, and assist him/her in identifying the self-defeating, negative consequences of this behavior. 14. Teach the client healthier and more constructive means of coping with emotional pain (e.g., sharing pain with others, attending Alcoholics Anonymous meetings, confronting and then forgiving the perpetrator, turning issues over to a higher power, setting healthy boundaries (see "Setting and Maintaining Boundaries" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
9. Cooperate with an evaluation by a physician for medication. (15, 16)	15. Assess the client's need for medication and arrange for medication evaluation, if appropriate. 16. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.
10. Enroll in dialectical behavior therapy. (17)	17. For client whose current distress and/or disability results from borderline traits, provide or refer to dialectical behavior therapist (see the chapter on borderline traits in this *Planner*).

11. Enroll in treatment for posttraumatic stress. (18)

18. For client who is manifesting posttraumatic stress disorder, provide or refer to prolonged exposure therapy, cognitive processing therapy, or eye movement desensitization and reprocessing therapy (see the chapter on posttraumatic stress disorder [PTSD] in this *Planner*).

12. Decrease feelings of shame by being able to verbally affirm self as not responsible for abuse. (19, 20, 21, 22)

19. Assign writing a letter to mother, father, or other abuser in which the client expresses his/her feelings regarding the abuse.

20. Hold conjoint sessions where the client confronts the perpetrator of the abuse.

21. Guide the client in an empty chair exercise with a key figure connected to the abuse, that is, perpetrator, sibling, or parent; reinforce the client for placing responsibility for the abuse or neglect on the caretaker (or assign "It Wasn't My Fault" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

22. Consistently reiterate that responsibility for the abuse falls on the abusive adults, not the surviving child (for deserving the abuse), and reinforce statements that accurately reflect placing blame on perpetrators and on nonprotective, nonnurturant adults.

13. Decrease statements of being a victim while increasing statements that reflect personal empowerment. (23, 24)

23. 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.

24. Encourage and reinforce the client's statements that reflect movement away from viewing self as a victim and toward personal empowerment as a survivor (or assign "Changing from Victim to Survivor" in the *Adult Psychotherapy Homework Planner* by Jongsma).

14. Increase level of trust of others as shown by more socialization and greater intimacy tolerance. (25, 26)

25. 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).

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

15. Learn and demonstrate honesty, openness, and assertiveness in communicating with others. (27, 28, 29)

27. Use modeling, role-playing, and behavior rehearsal to teach the client healthy problem-solving and communication skills to use in recovery (e.g., active listening, using "I messages," cooperation, compromise, and mutual respect).

28. Teach the client the healthy communication skills of being honest, asking for wants, and sharing feelings.

29. Using modeling, role-playing, and behavior rehearsal, teach the client healthy assertive skills; then practice these skills in several current problem situations.

16. Verbalize a plan as to how to fulfill the unmet needs of childhood now that adulthood has been reached. (30, 31)

30. Assist the client in identifying, understanding, and verbalizing unresolved needs, wishes, and wants from the childhood years (or assign "Corresponding with

My Childhood Self" in the *Addiction Treatment Homework Planner* by Finley and Lenz); then help him/her develop a written plan to meet each unmet need, wish, or want.

31. Have the client read material on resolving feelings surrounding childhood trauma (e.g., *Healing the Shame That Binds You* by Bradshaw and *Outgrowing the Pain* by Gil); then help him/her identify unresolved feelings, wishes, and wants.

17. Write a letter to the perpetrator, detailing the childhood abuse and its effect on one's thoughts, feelings, and behavior. (32)

32. Assign the client to write a letter to his/her perpetrator detailing the emotional trauma that resulted from the abuse (or assign "Feelings and Forgiveness Letter" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. Write a letter to each primary caregiver describing the childhood abuse and current feelings, wishes, and wants. (33)

33. Assist the client in writing a letter to each parent or primary caregiver, detailing his/her childhood abuse and sharing what the client wants from each person in recovery.

19. List five ways a higher power can assist in recovery from childhood trauma and addiction. (34)

34. Teach the client about the Adult Child of an Alcoholic/Alcoholics Anonymous/Narcotics Anonymous (ACA/AA/NA) concept of a higher power, and how the higher power can assist him/her in forgiving others and reestablishing self-esteem.

20. Verbalize an understanding of the power of forgiving perpetrators. (35, 36, 37, 38)

35. Help the client to understand that often perpetrators were wounded children also, and need to be forgiven and turned over to a higher power in order to not harbor rage at them.

36. 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).

37. Teach the client the benefits (e.g., release of hurt and anger, putting the issue in the past, opens the door for trust of others) of beginning a process of forgiveness (not necessarily forgetting or fraternizing with) of abusive adults.

38. Assign the client to write a forgiveness letter to the perpetrator of the abuse; process the letter.

21. Verbalize an understanding of how the home group in AA/NA can provide a substitute for an unhealthy family. (39)

39. Help the client to see how the new home ACA/AA/NA group can help to substitute for a healthy home that he/she never had.

22. Develop and agree to participate in a continuing care program to continue to recover from childhood abuse and addiction. (40)

40. Help the client to develop a continuing care program that includes regular attendance at recovery group meetings and the continued therapy necessary to recover from childhood trauma and addiction.

23. Complete a survey to assess the degree of satisfaction with treatment. (41)

41. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.02	Generalized Anxiety Disorder
	309.81	Posttraumatic Stress Disorder
	300.14	Dissociative Identity Disorder
	V61.21	Sexual Abuse of a Child (995.5, Victim)
	V61.21	Physical Abuse of a Child (995.5, Victim)
	V61.21	Neglect of Child (995.5, Victim)
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	_____	_____
	_____	_____

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

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

301.4	F60.5	Obsessive-Compulsive Personality Disorder
301.83	F60.3	Borderline Personality Disorder

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

CHRONIC PAIN*

BEHAVIORAL DEFINITIONS

1. Uses addictive medications to control pain.
2. Experiences pain beyond the normal healing process (6 months or more) and uses addictive medications as a primary coping skill.
3. Complains of generalized pain in many joints, muscles, and bones that debilitates normal functioning.
4. Overuse or use of increased amounts of medications with little, if any, pain relief.
5. Experiences tension, migraine, cluster, or chronic daily headaches of unknown origin.
6. Complains of chronic neck or back pain.
7. Experiences intermittent pain related to a medical disease.
8. Decreased or terminated activities (e.g., work, household chores, socializing, exercise, sex, or other pleasurable activities) because of pain and subsequent substance abuse.
9. Exhibits signs and symptoms of depression related to chronic pain syndrome.

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LONG-TERM GOALS

1. Discontinue opioid abuse and begin a program of recovery using the 12-step process as well as necessary pain management skills.
2. Regulate pain without addictive medications.
3. Find relief from pain and build renewed contentment and joy in performing activities of life.
4. Develop healthy options to deal with chronic pain.
5. Practice a program of recovery, including 12-step involvement and pain management skills.
6. Less daily suffering from pain and from substance abuse.
7. Accept chronic pain and engage in life as much as possible.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the nature, history, and impact of, and understood causes for, chronic pain and substance abuse. (1, 2)	1. Assess the manifestation of chronic pain, its history, current status, triggers, and methods of coping (see *The Handbook of Pain Assessment* by Turk and Melzack); assess substance use. 2. Assess the impact of the pain on the patient's functioning in everyday life, including changes in the client's mood, attitude, social, vocational, and familial/marital roles.
2. Cooperate with a thorough medical examination to rule out any alternative causes for the pain and to explore any new treatment possibilities. (3)	3. Refer the client to a physician or clinic to undergo a thorough examination to rule out any undiagnosed condition and to receive recommendations on any further treatment options.

3. Follow through on a pain management and substance abuse treatment program. (4)

4. Complete psychological testing or objective questionnaires for assessing the level of pain. (5)

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)

4. Discuss with the physician the cautious use of medications to manage chronic pain due to the client's pattern of substance abuse; make addiction a focus of treatment (assign "Coping With Addiction and Chronic Pain" from the *Addiction Treatment Homework Planner* by Finley and Lenz).

5. Administer to the client a psychological instrument designed to objectively assess chronic pain (e.g., McGill Pain Questionnaire Short Form-2); give the client feedback regarding the results of the assessment.

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. Follow through on a referral to a pain management specialist. (10, 11)	10. Make a referral to a pain management specialist of the client's choice and have him/her sign appropriate releases for the therapist to have progress updates from the program and to coordinate services. 11. Elicit from the client a verbal commitment to cooperate with the pain management specialists, headache clinic, or rehabilitation program.
7. Complete a thorough medication review by a physician who is a specialist in dealing with chronic pain and substance abuse. (12)	12. Ask the client to complete a medication review with a physician, including a discussion of the use of methadone and buprenorphine for pain management and narcotic withdrawal, if indicated.

8. Verbalize a statement of ownership of the pain and the addiction. (13)

9. Participate in a cognitive behavioral group therapy for pain management. (14)

10. Verbalize an understanding of pain. (15)

11. Verbalize an understanding of the rationale for treatment. (16, 17)

13. Assist the client in working through the defenses that prevent him/her from owning the pain and the substance abuse as his/hers.

14. Form a small, closed enrollment cognitive-behavioral treatment group (four to eight clients) for pain management (see *Group Therapy for Patients With Chronic Pain* by Keefe et al.; supplement with *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook* by Otis); or treat individually, if needed.

15. Teach the client key concepts of rehabilitation versus biological healing, conservative versus aggressive medical interventions, acute versus chronic pain, benign versus nonbenign pain, cure versus management, appropriate use of medication, role of self-regulation techniques, and other management techniques.

16. Teach the client a rationale for treatment that helps him/her understand that thoughts, feelings, and behavior can affect pain, and that there are coping techniques and skills that can be used to help him/her to adapt and respond to pain and the resultant problems; emphasize the role that the client can play in managing his/her own pain.

17. Assign the client to read sections from books or treatment manuals that describe pain conditions and their cognitive behavioral treatment (e.g., *The Chronic Pain Control Workbook* by Catalano and Hardin).

12. Identify and monitor specific pain triggers. (18)

13. Learn and implement somatic skills such as relaxation and/or biofeedback to reduce pain level. (19, 20, 21, 22, 23)

18. 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, and what was done to alleviate the pain (or assign "Pain and Stress Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal with the client to increase insight into the nature of the pain; cognitive, affective, and behavioral triggers; and the positive or negative effect of the interventions they are currently using.

19. Teach the client calming skills such as progressive muscle relaxation, guided imagery, deep diaphragmatic breathing, or mindfulness meditation (or assign "Self-Soothing: Calm Down, Slow Down" in the *Addiction Treatment Homework Planner* by Finley and Lenz); explain the rationale and how to apply these skills to his/her daily life (see *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens).

20. Refer the client for, or conduct, biofeedback training (e.g., EMG for muscle tension-related pain, thermal for migraine pain); assign practice of the skill at home.

21. Identify areas in the client's life where he/she can implement skills learned through relaxation or biofeedback.

22. Assign a homework exercise in which the client implements

	somatic pain management skills and records the result; review and process during the treatment session.
	23. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Living Beyond Your Pain* by Dahl and Lundgren).
14. Incorporate physical therapy/exercise into daily routine. (24)	24. Refer the client for physical therapy if pain is heterogeneous; request an individually tailored exercise program, if indicated, that is approved by his/her personal physician.
15. Learn mental coping skills and implement with somatic skills for managing acute pain. (25)	25. Teach the client distraction techniques (e.g., pleasant imagery, counting techniques, alternative focal point) and how to use them with relaxation skills for the management of acute episodes of pain (or assign "Controlling the Focus on Physical Problems" in the *Adult Psychotherapy Homework Planner* by Jongsma).
16. Participate in Acceptance and Commitment Therapy for chronic pain. (26)	26. Conduct Acceptance and Commitment Therapy including mindfulness strategies to help the client: decrease avoidance; disconnect thoughts from actions; accept one's experience rather than try to change or control symptoms; behave according to his/her broader life values; clarify his/her goals and values and commit to behaving accordingly (see *Acceptance and Commitment Therapy for Chronic Pain* by Dahl et al.).

17. Increase the level and range of activity by identifying and engaging in pleasurable activities. (27)

27. Ask the client to create a list of activities that are pleasurable to him/her (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the list, developing a plan of increasing the frequency of engaging in the selected pleasurable activities.

18. Incorporate physical exercise into daily routine. (28, 29)

28. Assist the client in recognizing the benefits of regular exercise, encouraging him/her to implement exercise in daily life and monitor results (see *Exercising Your Way to Better Mental Health* by Leith); offer ongoing encouragement to stay with the regimen.

29. Refer the client to an athletic club to develop an individually tailored exercise or physical therapy program that is approved by his/her personal physician.

19. Verbalize an accurate understanding of a cognitive-behavioral approach to pain management. (30)

30. Assign the client to read about cognitive-behavioral approaches to pain management in relevant books or treatment manuals (e.g., *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook* by Otis; *The Pain Survival Guide* by Turk and Winter; *The Chronic Pain Control Workbook* by Catalano and Hardin).

20. Identify, challenge, and change maladaptive thoughts and beliefs about pain and pain management and replace them with more adaptive thoughts and beliefs. (31, 32, 33, 34)

31. Explore the client's schema and self-talk that mediate his/her pain response, challenging the biases, assisting him/her in generating thoughts that correct for the biases, facilitate coping, and build confidence in managing pain.

32. Assign the client a homework exercise in which he/she identifies negative pain-related self-talk and positive alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

33. Use cognitive therapy techniques to help the client change his/her view of his/her pain and suffering from overwhelming to manageable.

34. Use cognitive therapy techniques to help the client change his/her self-concept and role in pain management from passive, reactive, and helpless to active, resourceful, and competent.

21. Learn and implement specific coping skills as well as when and how to use them to manage pain and its consequences. (35)

35. Teach the client specific coping skills based on an assessment of need (e.g., problem-solving, social/communication, conflict resolution, goal-setting).

22. Integrate and implement all new mental, somatic, and behavioral ways of managing pain. (36)

36. Assist the client in integrating his/her pain management skills learned in therapy (e.g., calming, cognitive coping, distraction, activity scheduling, problem-solving); transition use from therapy sessions to daily life as mastery becomes evident; review, reinforcing success and problem-solving obstacles toward the goal of integration (see *Psychological Approaches to Pain Management* by Turk and Gatchel).

23. Implement relapse prevention strategies for managing future challenges. (37, 38, 39)

37. Discuss with the client the distinction between a lapse and relapse, associating a lapse with

	an initial and reversible return of pain or old habits (e.g., a bad day) and relapse with the persistent return of pain and previous cognitive and behavioral habits that exacerbate pain.
	38. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur, using the strategies learned during therapy.
	39. Follow up with the client periodically to problem-solve difficulties and reinforce successes.
24. Verbalize an increased awareness of the mind-body connection. (40, 41)	40. Ask the client to read material on the mind-body connection (e.g., *Mind/Body Health: The Effects of Attitudes, Emotions, and Relationships* by Karren et al.) or attend a seminar related to holistic healing for insight into the mind-body connection.
	41. Assist the client in beginning to see the connection between chronic pain, substance abuse, and chronic stress.
25. Utilize spirituality to reduce tension and pain. (42, 43)	42. Teach the client about prayer and meditation and then assist him/her in implementing meditation into daily life.
	43. Visit with a member of the clergy and learn how to turn things over to a higher power.
26. Investigate the use of alternative pain remedies to reduce doctor visits and/or dependence on medication. (44)	44. Explore the client's alternatives to doctors and medications to remove or reduce his/her pain (or assign "Managing Pain Without Addictive Drugs" or "Coping

With Addiction and Chronic Pain" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

27. Complete a survey to assess the degree of satisfaction with treatment. (45)

45. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.89	Pain Disorder Associated With Both Psychological Factors and an Axis III Disorder
	307.80	Pain Disorder Associated With Psychological Factors
	300.81	Somatization Disorder
	300.11	Conversion Disorder
	300.82	Somatoform Disorder NOS
	296.3x	Major Depressive Disorder, Recurrent
	300.4	Dysthymic Disorder
	311	Depressive Disorder NOS
	316	Psychological Factors Affecting Medical Condition
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
	304.00	Opioid Dependence
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.89	F54	Psychological Factors Affecting Other Medical Conditions
307.80	F45.1	Somatic Symptom Disorder With Predominant Pain
300.81	F45.1	Somatic Symptom Disorder
300.11	F44.x	Conversion Disorder
300.82	F45.9	Unspecified Somatic Symptom and Related Disorder
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe

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

CONDUCT DISORDER/DELINQUENCY

BEHAVIORAL DEFINITIONS

1. Persistent refusal to comply with rules or expectations in the home, school, or community.
2. Use of mood-altering substances on a regular basis.
3. History of stealing at home, at school, or in the community.
4. School adjustment characterized by disrespectful attitude toward authority figures, frequent disruptive behaviors, and detentions or suspensions for misbehavior.
5. Repeated conflict with authority figures at home, at school, or in the community.
6. Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and destruction of property.
7. Numerous attempts to deceive others through lying, conning, or manipulating.
8. Consistent failure to accept responsibility for misbehavior accompanied by a pattern of blaming others.
9. Little or no remorse for misbehavior.
10. Lack of sensitivity to the thoughts, feelings, and needs of other people.
11. Multiple sexual partners, lack of emotional commitment, and engaging in unsafe sexual practices.
12. Impulsivity as manifested by poor judgment, taking inappropriate risks, and failing to stop and think about consequences of actions.
13. Participation in gang membership and activities.

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LONG-TERM GOALS

1. Comply with rules and expectations in the home, school, and community consistently.
2. Eliminate all illegal and antisocial behavior.
3. Terminate all acts of violence or cruelty toward people or animals and stop any destruction of property.
4. Demonstrate marked improvement in impulse control.
5. Express anger in a controlled, respectful manner on a consistent basis.
6. Terminate substance use behavior that compromises treatment of conduct disorder.
7. Parents establish and maintain appropriate parent–child boundaries, setting firm, consistent limits when the client acts out in an aggressive or rebellious manner.
8. Demonstrate empathy, concern, and sensitivity for the thoughts, feelings, and needs of others on a regular basis.

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SHORT-TERM OBJECTIVES

1. Identify situations, thoughts, and feelings that trigger angry feelings, problem behaviors, and the targets of those actions. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Using relevant verbal response modes (e.g., questioning, active listening, clarification, reflection, empathy), build rapport toward creating trust and a good working therapeutic alliance with the client.
2. Conduct clinical interviews with the client and parents focused on specifying the nature, severity, and history of the adolescent's misbehavior; thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger

	and the thoughts, feelings, and actions that have characterized his/her antisocial responses; consult with others (e.g., family members, teachers) and/or use parent/teacher rating scales (e.g., Child Behavior Checklist; Child Behavior Inventory) to supplement the assessment as necessary.
2. Parents identify major concerns regarding the child's misbehavior and the associated parenting approaches that have been tried. (3)	3. Assess how the parents have attempted to respond to the child's misbehavior; what triggers and reinforcements may be contributing to the behavior; the parents' consistency in their approach to the child, and whether they have experienced conflicts between themselves over how to react to the child.
3. Parents and child cooperate with psychological assessment to further delineate the nature of the presenting problem. (4)	4. Administer psychological instruments designed to assess whether a comorbid condition(s) (e.g., bipolar disorder, depression, attention-deficit/hyperactivity disorder [ADHD]) is contributing to disruptive behavior problems and/or objectively assess parent–child relational conflict (e.g., the Parent-Child Relationship Inventory); follow up accordingly with client and parents regarding treatment options; re-administer as needed to assess treatment outcome.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)	5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change;

	demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
	6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
	7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
	8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Complete a substance abuse evaluation and comply with the	9. Conduct a substance abuse evaluation and/or treatment for

recommendations offered by the evaluation findings. (9)

6. Cooperate with the recommendations or requirements mandated by the criminal justice system. (10, 11, 12)

7. Cooperate with a physician evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (13)

8. Recognize and verbalize how feelings are connected to misbehavior. (14)

the client; note how the substance abuse supports and encourages the conduct disorder and conduct disorder contributes to substance use (see the "Substance Use Disorders" chapter in this *Planner*).

10. Consult with criminal justice officials about the appropriate consequences for the client's destructive or aggressive behaviors (e.g., pay restitution, community service, probation, intensive surveillance).

11. Consult with parents, school officials, and criminal justice officials about the need to place the client in an alternative setting (e.g., foster home, group home, residential program, or juvenile detention facility).

12. Encourage and challenge the parents not to protect the client from the natural or legal consequences of his/her destructive or aggressive behaviors.

13. Assess the client for the need for psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.

14. Actively build the level of trust with the client through active listening and unconditional positive regard to help the client increase his/her ability to identify and express feelings instead of acting them out; assist the client

in making a connection between his/her feelings and reactive behaviors. EBP

9. Increase the number of statements that reflect the acceptance of responsibility for misbehavior. (15, 16, 17, 18)

15. Use techniques derived from motivational interviewing to move the client away from externalizing and blaming toward accepting responsibility from his/her actions and motivation to change.

16. Therapeutically confront statements about the client's antisocial behavior and attitude, pointing out consequences for himself/herself and others (or assign "How My Behavior Hurts Others" or "Patterns of Stealing" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Therapeutically confront statements in which the client lies and/or blames others for his/her misbehaviors and fails to accept responsibility for his/her actions; explore and process the factors that contribute to the client's pattern of blaming others (e.g., harsh punishment experiences, family pattern of blaming others).

18. Assist the client in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved physical health); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior.

EBP 10. Agree to learn alternative ways to think about and manage anger and misbehavior. (19, 20)

19. Assist the client in reconceptualizing anger as involving different components (cognitive, physiological,

affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met, leading to increased arousal and anger, leading to acting out) that can be managed (or assign "Is My Anger Due to Unmet Expectations?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

20. Assist the client in making a connection between his/her feelings and reactive behaviors (or assign "Surface Behavior/ Inner Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

11. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (21)

21. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings when they occur (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

12. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that facilitates more constructive reactions. (22)

22. Explore the client's self-talk and beliefs that mediate his/her angry feelings and actions (e.g., demanding expectations reflected in *should, must*, or *have to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that correct for the biases and facilitate a more flexible and temperate response to frustration (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

13. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out. (23)	23. Assign the client to implement a thought-stopping technique on a daily basis between sessions (or assign "Thought-Stopping" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review implementation; reinforce success, providing corrective feedback toward improvement.
14. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (24)	24. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction (see *Anger Control Training for Aggressive Youths* by Lochman et al.).
15. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (25)	25. Teach the client conflict resolution skills (e.g., empathy, problem-solving, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavioral rehearsal to work through several current conflicts (consider assigning "Becoming Assertive" or "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
16. Practice using new calming, communication, conflict resolution, and thinking skills in session with the therapist. (26, 27)	26. Assist the client in constructing and consolidating a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to their needs.
	27. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling,

role-playing, or feedback of videotaped practice in increasingly challenging situations to help the client consolidate the use of his/her new anger management skills (see *Problem-Solving Skills Training and Parent Management Training for Conduct Disorder* by Kazdin.).

17. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (28)

28. Assign the client homework exercises to help them practice newly learned calming (e.g., use "Self-Soothing: Calm Down, Slow Down" in the *Addiction Treatment Homework Planner* by Finley and Lenz), assertion (e.g., assign "Learning to Ask Instead of Demand" in the *Addiction Treatment Homework Planner* by Finley and Lenz), conflict-resolution (e.g., assign the exercise "Filing a Complaint" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis), cognitive restructuring (e.g., assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma), and anger management skills (e.g., assign "Anger Control" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis) as needed; review and process toward the goal of consolidation.

18. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (29)

29. Monitor the client's reports of angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the client's use of new anger

management skills (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma or "Anger as a Drug" in the *Addiction Treatment Homework Planner* by Finley and Lenz); review progress, reinforcing success and providing corrective feedback toward improvement.

19. Increase verbalizations of empathy and concern for other people. (30)

30. Use role-playing and role-reversal techniques to help the client develop sensitivity to the feelings of others in reaction to his/her antisocial behaviors (or assign "Trading Places" from the *Addiction Treatment Homework Planner* by Finley and Lenz).

20. Identify social supports that will help facilitate the implementation of new skills. (31)

31. Encourage the client to discuss and/or use his/her new anger and conduct management skills with trusted peers, family, or otherwise significant others who are likely to support his/her change.

21. Increase the frequency of responsible and positive social behaviors. (32, 33, 34)

32. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a developmentally disabled student, mow grandmother's lawn) before the next session to increase his/her empathy and sensitivity to the needs of others.

33. Assign homework designed to increase the client's empathy and sensitivity toward the thoughts, feelings, and needs of others (e.g., "Headed in the Right Direction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

34. Place the client in charge of tasks at home (e.g., preparing and cooking a special dish for a family get-together, building shelves in the garage, changing oil in the car) to demonstrate confidence in his/her ability to act responsibly.

22. Parents learn and implement Parent Management Training skills to recognize and manage the problem behavior of the client. (35, 36, 37, 38, 39)

35. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., *Parents and Adolescents Living Together: Family Problem Solving* by Forgatch and Patterson).

36. Ask the parents to read material consistent with a parent training approach to managing disruptive behavior (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together: Family Problem Solving* by Forgatch and Patterson).

37. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.

38. Teach parents how to implement key parenting practices consistently, including establishing

realistic age-appropriate rules for acceptable and unacceptable behavior; prompting of positive behavior in the environment; use of positive reinforcement to encourage behavior (e.g., praise); use of clear, direct instruction, time out, and other loss-of-privilege practices for problem behavior.

39. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" or "Catch Your Teen Being Responsible" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

23. Increase compliance with rules at home and school. (40)

40. Design a reward system and/or contingency contract for the client and meet with school officials to reinforce identified positive behaviors at home and school and deter impulsive or rebellious behaviors.

24. Client and family participate in family therapy. (41)

41. Refer family to an evidence-based family therapy such as Functional Family Therapy (see www.fftinc.com) or Brief Strategic Family Therapy (see *Brief Strategic Family Therapy for Hispanic Youth* by Robbins et al.) in which problematic interactions within the family system are assessed and changed through the use of family

systems and social learning interventions to support more adaptive communication and functioning.

25. Client and family participate in a Multisystemic Therapy program. (42)

42. Refer the client with severe conduct problems to a Multisystemic Therapy program with cognitive-behavioral and family interventions to target factors that are contributing to his/her antisocial behavior and/or substance use in an effort to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers and increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network (see *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* by Henggeler et al.).

26. Verbalize an understanding of the difference between a lapse and relapse. (43, 44)

43. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.

44. Discuss with the parent/child the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of thinking, feeling, and behaving that is characteristic of conduct disorder.

27. Implement strategies learned in therapy to counter lapses and prevent relapse. (45, 46, 47)

45. Identify and rehearse with the parent/child the management of future situations or circumstances in which lapses could occur; instruct the

parent/child to routinely use strategies learned in therapy (e.g., parent training techniques, problem-solving, anger management), building them into his/her life as much as possible.

46. Develop a coping card on which coping strategies and other important information can be kept (e.g., steps in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

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

28. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and his/her siblings. (48)

48. Explore the client's family background for a history of neglect and physical or sexual abuse that may contribute to his/her behavioral problems; confront the client's parents to cease physically abusive or overly punitive methods of discipline; implement the steps necessary to protect the client or siblings from further abuse (e.g., report abuse to the appropriate agencies; remove the client or perpetrator from the home).

29. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (49)

49. Encourage and support the client in expressing feelings associated with neglect, abuse, separation, or abandonment and help process (e.g., assign the task of writing a letter to an absent parent or use the empty chair technique).

30. Develop a written continuing care personal recovery plan to treat addiction and conduct disorder. (50)
31. Complete a survey to assess the degree of satisfaction with treatment. (51)

50. Assist the client in developing a long-term continuing care program to cope with conduct disorder and addiction.
51. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.81	Conduct Disorder, Childhood-Onset Type
	312.82	Conduct Disorder, Adolescent-Onset Type
	312.89	Conduct Disorder, Unspecified Onset
	313.81	Oppositional Defiant Disorder
	312.9	Disruptive Behavior Disorder NOS
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	312.34	Intermittent Explosive Disorder
	V71.02	Child or Adolescent Antisocial Behavior
	V61.20	Parent–Child Relational Problem
	V61.8	Sibling Relational Problem
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.82	F91.2	Conduct Disorder, Adolescent-Onset Type
313.81	F91.3	Oppositional Defiant Disorder

312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.9	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive /Impulsive Presentation
314.01	F90.9	Unspecified Attention-Deficit/ Hyperactivity Disorder
314.01	F90.8	Other Specified Attention-Deficit/ Hyperactivity Disorder
312.34	F63.81	Intermittent Explosive Disorder
V71.02	Z72.810	Child or Adolescent Antisocial Behavior
V61.20	Z62.820	Parent-Child Relational Problem
V61.8	Z62.891	Sibling Relational Problem

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

DANGEROUSNESS/LETHALITY

BEHAVIORAL DEFINITIONS

1. Exhibits low frustration tolerance and poor impulse control, with a history of violence.
2. Abuses mood-altering substances, in spite of many negative consequences, including dangerous effects to self.
3. Uses substance abuse to cope with negative emotions such as anger, hurt, embarrassment, or frustration.
4. Demonstrates poor anger management skills.
5. Acts aggressively and is uncooperative with staff and peers.
6. Refuses to listen to parents or authority figures.
7. Has attempted suicide or homicide.
8. Makes threats of physical harm to self or others.
9. Danger of violence escalates under the influence of mood-altering substances.

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LONG-TERM GOALS

1. Develop a program of recovery, free from substance abuse and dangerous, lethal behaviors.
2. Terminate all acts that are dangerous to self or others.
3. Verbalize the core conflicts that lead to dangerous/lethal behaviors.
4. Recognize the first signs of anger and use behavioral techniques to control it.

5. Increase self-esteem, purpose for living, and learn how to help others in recovery.
6. Maintain appropriate parent–child boundaries, setting firm limits when the client acts dangerously toward self or others.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Sign a contract agreeing to not harm self or others and to obey all rules while in treatment. (1, 2)	1. Request that the client sign a no-harm contract detailing that he/she will not harm himself/herself; ask the client to promise to tell a staff member if he/she feels an urge to be harmful to self or others. 2. Read the client the rules of treatment and ask him/her to sign an agreement that he/she will abide by all of the rules.
2. Cooperate with a referral for a medical evaluation. (3, 4)	3. Refer the client to be examined by a physician and/or psychiatrist for a medical evaluation; encourage an assessment for substance abuse effects, organic or neurological basis for violence, and the need for psychotropic medication. 4. Monitor the client for medication compliance, effectiveness, and side effects.
3. Cooperate with a biopsychosocial examination. (5, 6)	5. Complete a biopsychosocial (e.g., family history of violence and substance abuse, childhood

history of violence, chemical dependence, social relationships) examination.

6. Meet with family members to obtain their perspective on the client's substance abuse and violence.

4. Complete psychological testing or objective questionnaires for assessing violence toward self and others. (7)

7. Administer to the client psychological instruments designed to objectively assess violence toward self or others (e.g., Beck Scale for Suicide Ideation, Domestic Violence Inventory); give the client feedback regarding the results of the assessment and retest as necessary to assess progress in treatment.

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. (8, 9, 10, 11)

8. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
	10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
	11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
6. Identify three somatic sensations that occur with building hurt, fear, or anger. (12)	12. Assist the client in identifying three somatic feelings that accompany feelings of hurt, fear, and anger (or assign "Is My Anger Due to Feeling Threatened?" or "Is My Anger Due to Unmet Expectations?" in the *Addiction Treatment Homework Planner* by Finley and Lenz); assess how the client copes with these feelings.
7. Identify the current degree of threat that exists to self or others. (13, 14)	13. Assess the client for his/her degree of urge to harm self, degree of plan development, access to means of harm, history of previous attempts, degree of hopelessness or hurt related to relationship dissolution, and

any other factors that increase suicide risk; consider inpatient treatment if indicated.

14. Assess the client for his/her degree of urge to harm others; degree of plan development; history of violence, threats made, relationship conflict, possessiveness, or stalking of victim; criminal history; history of restraining orders; use of substance abuse to cope with anger, hurt, or depression. Consider the duty to warn if risk is significant.

8. List five things the client can do when angry to cope with feelings. (15)

15. Help the client to make a list of five things he/she can do when feeling angry to cope with angry feelings (e.g., relaxing using deep breathing; processing the situation to stop, think, and plan accurately; separating from the situation to give time to calm down before responding; using cardiovascular exercise).

9. Keep an anger journal describing the situations that cause anger. (16, 17)

16. Teach the client how to keep an anger journal, using subjective units of distress as a measurement of the intensity of the dangerous/lethal feelings, giving the anger a subjective unit of distress score from 1 (as little anger as possible) to 100 (as much anger as possible).

17. Review the client's anger journal and teach the client how inaccurate thinking leads to angry feelings and how thinking accurately can eliminate aggression.

10. Practice relaxation skills twice each day for 10 to 20 minutes. (18)

18. Using progressive relaxation techniques, teach the client how to relax (or assign the "Safe and

	Peaceful Place Meditation" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz); ask the client to rate the extent of relaxation achieved on a scale of 1 to 10.
11. Participate in physical exercise each day. (19)	19. Encourage the client to participate in exercise for at least 20 minutes each day; monitor implementation, reinforcing success and redirecting for failure.
12. Identify the possible causes of dangerous and lethal behaviors. (20)	20. Explore with the client his/her family-of-origin issues (e.g., physical abuse, abandonment, sexual abuse, gang affiliation, parental chemical dependence, etc.) that may have led to dangerous and lethal behaviors (or assign the "Understanding Family History" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).
13. List five ways dangerous and lethal behaviors contribute to substance abuse and vice versa. (21, 22)	21. Help the client to make a list of five ways that dangerous and lethal behaviors have contributed to substance abuse, and have the client share this list in group.
	22. Assist the client in listing five ways that substance abuse contributes to dangerous and lethal behaviors (e.g., deepens depression and shame, reduces inhibition to reason with self or others).
14. Verbalize an understanding of how anger can be used as a drug to quickly change the way we feel. (23)	23. Ask the client to review how he/she may have used anger as a way to avoid or escape negative feelings like hurt, shame, or depression (or assign "Anger as a Drug" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

15. Verbalize an understanding of the benefits of respect versus the detriments of fear from others. (24)

16. Verbalize acceptance of powerlessness and unmanageability of substance abuse and dangerous and lethal behaviors. (25)

17. Verbalize an understanding of Alcoholics Anonymous's (AA's) Steps 2 and 3, and list three ways a higher power can assist in recovery. (26)

18. Complete an AA Step 4 and Step 5 exercise that includes a history of past assets and liabilities, discussing the exact nature of wrongs. (27, 28)

19. Parents verbalize an understanding of their child's aggressiveness and its interaction with substance abuse. (29, 30)

24. Assist the client in listing five instances in which he/she used dangerous behavior as a means of intimidating others; discuss the difference between causing others to fear versus respect someone.

25. Discuss the meaning of powerlessness and unmanageability in the recovery program and show how this step can be used to manage dangerous and lethal behaviors.

26. Teach the client about Steps 2 and 3 of AA (or assign the Step 2 and Step 3 exercises in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson); then show three ways a higher power can assist him/her in recovery.

27. Have the client complete a Step 4 inventory of who are the targets of anger and resentment, why they are resented, and how this has affected the client (or assign the Step 4 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

28. As part of a fifth step, ask the client to share how he/she has wronged others.

29. Meet with family members and discuss dangerousness and lethal behaviors and substance abuse, talking about what the client is going to do differently in recovery.

30. Assign the parents to read *Parenting Your Out-of-Control Teenager* by Sells and discuss with them measures to reestablish control over their child.

20. Sign a behavior contract that lists all behavior expected in recovery and the consequences of failing to meet these contractual obligations. (31)

21. Complete a survey to assess the degree of satisfaction with treatment. (32)

31. Develop with the family a behavior contract that outlines what the client will do in recovery and the consequences of failing to meet these contractual obligations.

32. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
	296.xx	Major Depressive Disorder
	V71.01	Adult Antisocial Behavior
	_____	_____
	_____	_____
Axis II:	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.8	F91.x	Conduct Disorder
313.81	F91.3	Oppositional Defiant Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
312.34	F63.81	Intermittent Explosive Disorder
309.4	F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
301.0	F60.0	Paranoid Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

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

DEPENDENT TRAITS

BEHAVIORAL DEFINITIONS

1. Passively submits to the wishes, wants, and needs of others to the exclusion of the client's own wishes.
2. Dependent traits have fostered engagement in addictive behavior.
3. Chronically fears interpersonal abandonment and desperately clings to destructive relationships.
4. Goes to excessive lengths to gain acceptance from others to the point of volunteering to do unpleasant things.
5. Has a history of being anxious about making decisions without an excessive amount of advice and support from others.
6. Lacks ability to trust own judgment about everyday life decisions.
7. Persistently feels worthless and helpless, and believes rejection is inevitable.
8. Needs others to assume responsibility and make most major decisions.
9. Fears group situations unless certain of being accepted.
10. Chronically feels alienation from others.

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LONG-TERM GOALS

1. Recovery from substance abuse, which reduces the impact of dependent traits on addiction.
2. Demonstrate increased independence and self-confidence through autonomous decision-making, honest expression of feelings and ideas, and reduced fear of rejection.

3. Decrease dependence on relationships while beginning to meet own needs, build confidence, and practice assertive skills.
4. Demonstrate healthy communication that is honest, open, and self-disclosing.
5. Reduce the frequency of behaviors exclusively designed to please others.
6. Reduce feelings of alienation by learning similarity to others who were raised in a more normal home.

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SHORT-TERM OBJECTIVES

1. Acknowledge the feelings of powerlessness and unmanageability that result from dependent traits and addictive behavior. (1)

2. Complete psychological testing or objective questionnaires for assessing dependent traits. (2)

3. Identify at least five dynamics of early family life that contributed to developing dependent traits. (3, 4, 5, 6, 7)

THERAPEUTIC INTERVENTIONS

1. Probe the feelings of powerlessness that the client experienced as a child and how these feelings are similar to how he/she feels when engaging in dependent and addictive behavior.

2. Administer to the client psychological instruments designed to objectively assess dependent traits and addictive behavior (e.g., Millon Clinical Multiaxial Inventory—III); give the client feedback regarding the results of the assessment and test again, if necessary, to assess treatment progress.

3. Educate the client about the childhood etiology of his/her fear of making decisions and how this is not appropriate as an adult (or assign "Understanding Family History" in the *Addiction*

	Treatment Homework Planner by Finley and Lenz). 4. Explore how the dysfunctional family's inconsistent rules led to the client's fear of failure. 5. Teach the client about how low self-esteem and fear of making the wrong choice resulted from being raised in a home where family members were overly controlling and critical. 6. Explore the influence that the client's fear and shame had on choosing a lifestyle of dependent traits and addictive behavior. 7. Ask the client to identify at least five instances in which he/she avoided decisions out of fear of failure or rejection (or assign "Making Your Own Decisions" in the *Adult Psychotherapy Homework Planner* by Jongsma).
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)	8. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change). 9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
	10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
	11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Identify five incidents in which dependent traits were used to avoid the anxiety of making decisions that could have resulted in failure. (12)	12. Assist the client in identifying five incidents where his/her inability to trust his/her own judgment led to a dependent pattern of avoiding making decisions; raise his/her awareness of this tendency and explore its origins.
6. Verbalize an understanding of how dependent traits contributed to addictive behavior. (13)	13. Discuss the relationship between the client's dependent traits and his/her addictive behavior; explore how dependency has fostered addictive behavior to escape anxiety.

7. Identify abandonment experiences in the family of origin and verbalize how this has influenced current relationships. (14, 15, 16)

14. Explore the client's childhood experiences of abandonment and neglect; relate these to his/her dependent traits and addictive behavior.

15. Raise the client's awareness of his/her tendency to take over the child role in relationships; explore causes for this pattern in the client's childhood abandonment and rejection experiences (or assign "Satisfying Unmet Emotional Needs" in the *Adult Psychotherapy Homework Planner* by Jongsma).

16. Assist the client in understanding how his/her early childhood experiences led to a fear of decision-making that might lead to abandonment, rejection, and neglect, and the assumption of a child-like role as a defense (or assign "Taking Steps Toward Independence" in the *Adult Psychotherapy Homework Planner* by Jongsma).

8. Share the feeling of worthlessness that was learned in the family and relate this feeling to addictive behavior as a coping mechanism. (17)

17. Assist the client in identifying a pattern of using addictive behavior as an escape from feelings of anxiety and worthlessness that is based in his/her dysfunctional family background.

9. Learn and implement relaxation skills to counteract anxiety in interpersonal situations. (18, 19)

18. Teach the client relaxation procedures (e.g., deep muscle release, rhythmic deep breathing, positive imagery) as a coping technique for anxiety (or assign the "Self-Soothing: Calm Down, Slow Down" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).

19. Role-play instances in which the client could implement

	relaxation techniques as a healthy escape from interpersonal anxiety; monitor and reinforce implementation of this skill in daily life.
10. Openly share thoughts, feelings, and problems regarding the negative consequences of disclosure of emotions and desires within the family. (20, 21)	20. Explore how the client's family responded to expressions of feelings, wishes, and needs, and why the client became anxious when he/she expressed a choice, feeling, or decision.
	21. Educate the client about healthy interpersonal relationships based on openness, respect, and honesty, and explain the necessity of sharing feelings to build trust and mutual understanding (or assign the "Negotiating Skills for Success" or "Building My Support Network" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).
11. Document two incidents per week of telling the truth rather than only saying what the other person wanted to hear. (22)	22. Teach the client about how the behavior of telling other people what we think they want to hear—rather than the truth—is based on a fear of rejection learned in the family; use behavior rehearsal to teach the client more honest communication skills (or assign the client to complete the "How Interdependent Am I?" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).
12. Learn assertiveness skills and implement them in daily social interactions. (23, 24)	23. Teach the client the assertive formula of "I feel _____ when you _____; I would prefer it if _____," role-playing several applications to his/her life; have the client journal one assertive situation each day.

24. Use modeling, behavior rehearsal, and role-playing to teach the client healthy assertiveness skills; then assign the application of these skills to several current problem situations.

13. Verbalize an understanding of how dependent traits contributed to choosing partners and friends who were demeaning and controlling. (25)

25. Review the client's choice of friends and intimate partners; relate his/her dependency traits to selection of demeaning and controlling people.

14. Document and report on the process of implementing decision-making skills in at least three situations per week. (26, 27, 28)

26. Teach the client problem-solving skills (e.g., identify the problem, brainstorm alternate solutions, examine the advantages and disadvantages of each option, select an option, implement a course of action, and evaluate the result); role-play solving a problem drawn from the client's life experience.

27. Educate the client about how the fear of making decisions is based on low self-esteem.

28. Assign the client to implement problem-solving/decision-making skills at least three times per week and record the process and feelings; review, reinforce, and redirect when necessary.

15. Begin to take more independent action rather than seeking help and reassurance. (29)

29. Assist the client in listing five things he/she does independently or without assurance from others; then ask the client to list five activities that are avoided due to lack of confidence; discuss how to move the latter activities to the list of independent actions (or assign "How Interdependent Am I?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

16. Discuss fears related to attendance at recovery group meetings and verbalize specific plans to deal with each fear. (30, 31)

17. List reasons why regular attendance at recovery group meetings is helpful in arresting dependent traits and addictions. (32, 33)

18. Report on successfully contacting a sponsor within the 12-step community. (34)

19. List ways that belief in an interaction with a higher power can reduce fears and aid in recovery. (35)

30. Teach the client how becoming actively involved in a 12-step recovery group can aid in building trust in others and confidence in self.

31. Probe the relationship between the client's dependent traits and fear of attending recovery group meetings; assist the client in identifying coping skills (e.g., relaxation techniques, going to meetings with a sponsor, positive self-talk, assertiveness skills) to overcome fears.

32. Assist the client in developing an aftercare plan centered on regular attendance at a 12-step recovery group meeting.

33. Discuss how the 12-step home group can be like the healthy family the client never had; help the client list reasons why he/she needs such a group to recover (e.g., "I need love and support from people in recovery," "I want a new family to help me," "I need brothers and sisters in recovery to keep me in recovery").

34. Educate the client about the importance of sponsorship within the 12-step community and facilitate his/her establishment of a relationship with a sponsor.

35. Teach the client about the positive ways that faith in a higher power can aid in recovery and arrest the fear associated with dependent traits and addiction (e.g., regular attendance at worship services, daily prayer, and meditation).

20. Verbalize a feeling of serenity that results from turning problems that are out of one's own control over to a higher power. (36)
21. Read portions of recovery literature six days per week and share insights obtained with others. (37)
22. Develop a written long-term continuing care treatment plan to address addiction and dependent traits. (38)
23. Complete a survey to assess the degree of satisfaction with treatment. (39)

36. Review and reinforce the client's enactment of faith in a higher power in his/her daily life.
37. Assign the client to read recovery literature (e.g., Adult Child of an Alcoholic *Red Book* and/or Alcoholic Anonymous *Big Book*) and process the material in an individual or group therapy session.
38. Assist the client in developing a long-term continuing care plan to address addiction and dependent traits.
39. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	300.02	Generalized Anxiety Disorder
	300.23	Social Phobia
	V61.20	Parent–Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder

301.50	Histrionic Personality Disorder
301.9	Personality Disorder NOS
_____	_____
_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.4	F34.1	Persistent Depressive Disorder
300.02	F41.1	Generalized Anxiety Disorder
300.23	F40.10	Social Anxiety Disorder
V61.20	Z62.820	Parent–Child Relational Problem
301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.50	F60.4	Histrionic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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EATING DISORDERS AND OBESITY*

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

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

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SHORT-TERM OBJECTIVES

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

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.

	2. Assess the historical course of the disorder including the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food); probe perceived personal and interpersonal triggers and personal goals (or assign "Eating Patterns Self-Assessment" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	3. Compare the client's calorie consumption with an average adult rate of 1,900 (for women) to 2,500 (for men) calories per day to determine over- or undereating.
	4. Measure the client's weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image.
2. Describe any regular use of unhealthy weight control behaviors. (5)	5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise. Monitor on an ongoing basis.
3. Complete psychological tests designed to assess and track eating patterns and unhealthy weight-loss practices. (6)	6. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the Eating Inventory; Eating Disorder Scale; or Eating Disorders Inventory–3); give the client feedback regarding the results of the assessment; readminister as needed to assess treatment response.

4. Disclose any history of substance use that may contribute to and complicate the treatment of eating disorders or obesity. (7)

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. (8, 9, 10, 11)

7. Complete a substance use evaluation and make chemical dependence a focus of treatment if the evaluation recommends it (see the Substance Use Disorders chapter in this *Planner*).

8. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

11. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
6. Cooperate with a complete medical evaluation. (12)	12. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client's medical condition.
7. Cooperate with a dental exam. (13)	13. Refer the client to a dentist for a dental exam.
8. Cooperate with an evaluation by a physician for psychotropic medication. (14, 15)	14. Assess the client's need for psychotropic medications (e.g., Selective Serotonin Reuptake Inhibitors [SSRIs]; arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated.
	15. Monitor the client's psychotropic medication prescription compliance, effectiveness, and side effects.
9. Cooperate with admission to inpatient treatment, if indicated. (16)	16. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal).

10. Verbalize an accurate understanding of how eating disorders develop. (17)

11. Verbalize an understanding of the rationale and goals of treatment. (18, 19)

17. Teach the client a model of eating disorders development that includes concepts such as sociocultural pressures to be thin, overvaluation of body shape and size in determining self-image, maladaptive eating habits (e.g., fasting, bingeing, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn; *The Eating Disorder Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders* by Costin).

18. Discuss a rationale for treatment consistent with the model being used, including how cognitive, behavioral, interpersonal, lifestyle, and/or nutritional factors can promote poor self-image, uncontrolled eating, and unhealthy compensatory actions, and how changing them can build physical and mental health-promoting eating practices (assign "Creating a Preliminary Eating and Health Plan" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

19. Assign the client to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with the treatment model (e.g., *Overcoming Binge Eating* by Fairburn; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy*

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

client's uncontrolled eating and/or compensatory weight management behaviors.

27. Direct and assist the client in construction of a hierarchy of high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors.

16. Learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices. (28)

28. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, problem-solving, conflict resolution (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), or other social/communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations.

17. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (29)

29. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real-life implementation by the client, reinforcing success while providing corrective feedback toward improvement.

18. Identify, challenge, and replace self-talk and beliefs that promote the eating disorder. (30, 31, 32)

30. Conduct Phase 1 of Cognitive Behavioral Therapy (see *Cognitive Behavior Therapy and Eating Disorders* by Fairburn) to help the client understand the adverse effects of bingeing and

purging; assigning self-monitoring of weight and eating patterns and establishing a regular pattern of eating (use "A Reality Journal: Food, Weight, Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material.

31. Conduct Phase 2 of Cognitive Behavioral Therapy (CBT) to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that mediate feelings and actions, leading to maladaptive eating and weight control practices (or assign "How Fears Control My Eating" from the *Adult Psychotherapy Homework Planner* by Jongsma).

32. Conduct Phase 3 of CBT to assist the client in developing a maintenance and relapse prevention plan including self-monitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting short-term goals to stay on track.

19. To begin to resolve bulimic behavior, identify important people in the past and present, and describe the quality, good and poor, of those relationships. (33)

33. Conduct Interpersonal Therapy (see *Interpersonal Psychotherapy for Bulimia Nervosa* by Fairburn) beginning with the assessment of the client's interpersonal inventory of important past and present relationships, highlighting themes that may be supporting the eating

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

strictly adhere to the treatment plan, taking a history of the eating disorder, clarifying that the parents will be in charge of weight restoration of the client, establishing healthy weight goals, and asking the family to participate in the family meal in session; establish with the parents and a physician a minimum daily caloric intake for the client and focus them on meal planning; consult with a physician and/or nutritionist if fluids and electrolytes need monitoring due to poor nutritional habits.

39. Conduct Phase 2 of FBT (sessions 11–16) by continuing to closely monitor the client's weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved and portions consumed are nearing what is normally expected and weight gain is demonstrated.

40. Conduct Phase 3 of FBT (sessions 17–20) by reviewing and reinforcing the client's progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills.

22. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41)

41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic spiritual value.

23. Follow through on implementing the five aspects of the LEARN program to achieve weight loss. (42, 43)	42. Assign the client to read the LEARN manual (see *The LEARN Program for Weight Management* by Brownell) and then review the five aspects of the program (i.e., Lifestyle, Exercise, Attitudes, Relationships, and Nutrition) that will be emphasized over the next 12 weeks.
	43. In weekly sessions, systematically work through the five aspects of the LEARN program manual (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition), applying each component to the client's life to establish new behavioral patterns designed to achieve weight loss.
24. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (44, 45)	44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, bingeing, then purging).
	45. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.
25. Implement relapse prevention strategies for managing possible future anxiety symptoms. (46, 47, 48)	46. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse.
	47. Develop a maintenance plan with the client that describes how the client plans to identify challenges, use knowledge and

skills learned in therapy to manage them, and maintain positive changes gained in therapy.

48. Schedule periodic maintenance sessions to help the client maintain therapeutic gains and adjust to life without the eating disorder.

26. Verbalize an understanding of how fear of abandonment is expressed in eating disorders and addictive behavior. (49, 50)

49. Probe the relationship between the client's feelings of anger, sadness, or fear of abandonment and the eating disorder and other addictive behaviors.

50. Assist the client in identifying triggers for fear of abandonment, and possible historical causes for these feelings being so predominant.

27. Attend an eating disorder group. (51)

51. Refer the client to a support group for eating disorders or obesity.

28. Develop a 5-year continuing care plan to recover from addiction and eating disorder. (52)

52. Assist the client in developing a 5-year continuing care plan that includes active involvement in a 12-step recovery group and use of newly learned coping skills.

29. Complete a survey to assess the degree of satisfaction with treatment. (53)

53. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.1	Anorexia Nervosa
	307.51	Bulimia Nervosa
	307.50	Eating Disorder NOS
	307.51	Binge Eating Disorder
	316	Psychological Symptoms Affecting Axis III Disorder (e.g., obesity)
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.1	F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
278.00	E66.9	Overweight or Obesity
307.50	F50.9	Unspecified Feeding or Eating Disorder
307.59	F50.8	Other Specified Feeding or Eating Disorder
307.51	F50.8	Binge Eating Disorder
316	F54	Psychological Factors Affecting Other Medical Conditions (Obesity)
301.6	F60.7	Dependent Personality Disorder

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

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

FAMILY CONFLICTS

BEHAVIORAL DEFINITIONS

1. Exhibits a pattern of family conflicts leading to dysfunctional relationships and addiction.
2. Describes a family that engages in repeated physical fights, verbal arguments, and/or unresolved disputes.
3. Demonstrates poor communication skills, leading to an inability to solve family problems.
4. Admits to physical or verbal abuse of family members.
5. Uses addiction to cope with feelings of anger, alienation, or depression related to conflict within the family.
6. The family has a history of unresolved intrafamily conflicts leading to distrust and alienation.
7. Experiences long periods of noncommunication with family members due to unresolved conflicts.
8. Describes a family that is not supportive to recovery.
9. Has a history of addiction in family members, leading to a poor recovery environment.
10. An adult child continues to live in the parental home without consistent efforts to become financially and emotionally independent and emancipated.

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LONG-TERM GOALS

1. Maintain a program of recovery that is free of addiction and family conflict.
2. Learn and demonstrate healthy communication and conflict resolution skills, leading to harmony within the family and the cessation of addiction.
3. Forgive family members' past misdeeds and begin a life of harmony with each family member.
4. Terminate addiction and implement more healthy coping behaviors to deal with conflicts within the family.
5. Begin to emancipate from the parents in a healthy way by making reasonable arrangements for independent living.
6. Parents increase their cooperation and mutual support in dealing with their children.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that have resulted from using addictive behavior to cope with family conflicts. (1, 2)

2. Identify the nature and history of current family conflicts. (3)

3. Complete or give permission for a significant other to complete a survey of the client's family. (4)

THERAPEUTIC INTERVENTIONS

1. Help the client to see the powerlessness and unmanageability that have resulted from using addiction to cope with family conflicts.

2. Assist the client in understanding the vicious cycle that results from reacting to family conflicts with addictive behaviors.

3. Explore the client's history to identify the nature of and causes for the current family conflicts.

4. Administer to the client or a significant other an objective survey (e.g., Family Environment Scale; Family Relationship Inventory; or Family System Test) to assess the client's family;

give the client feedback regarding the results of the assessment; readminister as needed to assess treatment response.

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

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe

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

5. Verbalize how current family conflicts relate to conflicts in the family of origin that were experienced as a child. (9)

9. Help the client to see the relationship between the family-of-origin childhood conflicts and current family conflicts; assign him/her to write a detailed account of how the two are related.

6. Acknowledge that attempts to seize power and control within the family lead to unhealthy interpersonal relationships. (10, 11)

10. Assist the client in identifying how he/she has attempted to seize power and control within the family.

11. Teach the client about respect for independence and autonomy in a healthy family, and help the client to see how power struggles led to unresolved family conflicts.

7. Family members give individual perspectives on current conflicts. (12)

12. In a family session, make a list of current family conflicts from each member's perspective (or assign "Identifying Conflict Themes" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

8. Family members identify and implement changes that each one must make to reduce conflict. (13, 14, 15)

13. Assist each family member in identifying what he/she could do to reduce family conflicts and heal the wounds of the past.

14. Develop a written contract that outlines what each family member will do to resolve family conflicts.

15. Review the family members' implementation of changes to reduce conflict; reinforce success, confront projection, and redirect for failures.

9. In a family session, verbalize how addiction fosters misunderstanding and conflict and how conflict fosters addiction. (16)

16. Help the family members understand how family conflict increases the probability of addictive behavior and how addictive behavior increases the probability of family conflict.

10. Write a letter to each family member, taking responsibility for past misdeeds, stating remorseful feelings, and asking for support from each member during recovery. (17, 18)

17. Help the client write a letter to each family member, taking responsibility for problems in the past, sharing his/her feelings, and asking what he/she would like from each family member to support his/her recovery.

18. Confront the client when he/she blames others and does not accept responsibility for his/her own role in the family conflict.

11. Family members read letters sharing how they feel and stating what behavior they would like from the client during his/her recovery. (19)

19. Help each family member write a letter to the client stating how they feel, and asking for what they would like from him/her during recovery; ask each member to read the letter to the client in a family session.

12. Family members and the client participate in Family Behavior Therapy. (20)

20. Conduct or refer family to Family Behavioral Therapy (see *Family Behavior Therapy* by Donahue and Azrin).

13. Family members identify realistic personal and family goals. (21)

21. Have each family member identify personal and family goals; discuss identifying a set of realistic goals that can be tracked through therapy.

14. Family members participate in developing a treatment plan sequence. (22)

22. Facilitate the development of a treatment plan sequence by asking family members to rate goals in terms of importance; use

this information and other relevant considerations to lay out a treatment plan.

15. Identify any emergency or potential emergency situations that need to be addressed. (23)

23. Teach the client skills (e.g., assertion and problem-solving skills to make requests of creditors, landlords, etc.) tailored to identifying emergency or potential emergency situations (e.g., violence, having utilities turned off due to nonpayments, medical emergencies, loss of job, eviction, unsanitary conditions).

16. Decrease contact with people, places, and activities associated with drug use; increase time with safe people and activities. (24)

24. Teach the client to identify, monitor, and eliminate or control people, places, or activities that increase the likelihood of drug use and associated behavior problems, and increase time spent in activities that decrease their likelihood.

17. Learn and implement skills to manage thoughts, urges, and physical sensations related to drug use and associated behavior problems (e.g., child neglect); replace these thoughts and actions with those facilitative of prosocial thoughts and actions. (25)

25. Use cognitive therapy and self-control techniques (e.g., identifying thoughts, urges, and emotional-physical sensations associated with drug use); teach thought-stopping, having the client redirect self to alternative, competing thoughts, feelings, and actions (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. Learn and implement self-control skills to manage high-risk, problem situations within the family. (26)

26. Teach the client self-control strategies using role playing, modeling, and imaginal rehearsal (e.g., scenes in which he/she identifies family-linked triggers such as thoughts, feelings, images, and actions to drug use

	or problem behavior; uses thought-stopping and relaxation; reviews potential negative consequences; reviews prosocial alternative actions, etc.). Provide feedback, including praise and suggestions for future improvement (see *Family Behavior Therapy* by Donahue and Azrin). EBP
EBP 19. Parents learn parenting skills. (27, 28)	27. Ask the parents to read material consistent with a parent training approach to managing disruptive children's behavior (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together: The Basics* by Patterson and Forgatch; *Parents and Adolescents Living Together: Family Problem Solving* by Patterson and Forgatch). EBP
	28. Teach the parents parenting skills (e.g., attending, reinforcing, praising, tactile reinforcement, pleasant tone, and ignoring undesired behaviors) through role-play with the client; assign homework to practice "catching their children being good" while ignoring undesired behaviors (or assign "A Structured Parenting Plan" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBP
EBP 20. Learn and implement positive parenting techniques. (29)	29. Teach the parents to discipline undesired behaviors by telling the child that the undesired behavior was at least partially a product of the situation, and then instruct the child to practice the desired behavior; assign as homework and review toward improving skills. EBP

21. Family members agree to implement a contingency contract. (30)

30. Help the family develop a positive reinforcement system for performance of behaviors that are incompatible with drug use (e.g., school/work attendance, coming home when expected, doing chores, spending time with parents), with restriction of these reinforcers when drug use occurs (or assign "Using Reinforcement Principles in Parenting" in the *Adult Psychotherapy Homework Planner* by Jongsma).

22. Learn and implement personal coping skills to manage common day-to-day challenges within the family without the use of substances. (31)

31. Assess current skill (e.g., problem-solving, relaxation, positive parenting, assertiveness, etc.) in managing common everyday family stressors; use behavioral techniques (e.g., instruction, modeling, role-playing) to build skills to manage these challenges without the use of substances.

23. Learn and implement assertive communication skills to be used among family members. (32)

32. Using modeling, role-playing, and behavior rehearsal, teach the client and family members assertive communication skills (e.g., call someone; go to a meeting; use "I messages"; use simple, empathic, and confrontational assertion) (or assign the client to complete the "Communication Skills" exercise from the *Addiction Treatment Homework Planner* by Finley and Lenz).

24. Learn and implement problem-solving skills for use in approaching family problems. (33)

33. Using modeling, role-playing, and behavior rehearsal, teach the client and family members a problem-solving approach to conceptualizing and addressing problems including defining the problem, generating options, evaluating the pros and cons of

	each option, developing a plan, implementing, reevaluating, and adapting (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).
25. Learn and implement conflict resolution skills to be used during a family argument. (34)	34. Using modeling, role-playing, and behavior rehearsal, teach the client and family members what to do when he/she is in a family conflict (e.g., call someone; go to a meeting; use "I messages"; accept the responsibility for his/her own behavior, don't blame; turn it over to a higher power; stop, look, listen, think, and plan before acting).
26. Learn and implement refusal skill. (35)	35. Using modeling, role-playing, and behavior rehearsal, teach the client how to say no to alcohol/drugs; practice refusal in several high-risk situations.
27. Structure time and increase self-esteem by obtaining employment. (36)	36. Refer the client to a supported employment program, or coach the client on preparing for employment, searching for a job, and maintaining employment (see the "Occupational Problems" chapter in this *Planner*).
28. Learn and implement financial management skills. (37)	37. Teach financial management skills including learning how to identify if the family is in financial deficit or surplus, learning to obtain and manage additional income, and prioritizing expenses (or assign "Plan a Budget" in the *Adult Psychotherapy Homework Planner* by Jongsma).
29. Allow home visit to assess family living environment. (38)	38. Tour the family's home to praise efforts to prevent home hazards

and maintain a clean, stimulating and well-organized home; assess home health hazards (i.e., toxins, electrical hazards, adequate food/nutrition, maintenance of medical check-ups, etc.), home cleanliness, equipment, and materials facilitating personal and social growth of children (i.e., toys, books, clothing, home decorations); prompt family members to recognize hazards, praise for discovering and implementing solutions, and assist with the generation and implementation of solutions.

30. Plan and implement pleasurable family activities that promote communication and bonding. (39)

39. Assist the family in identifying and planning several pleasurable family activities in which all family members participate, such as eating dinner together, going to church together, bowling, bike riding, playing a table game, etc. (or assign "Creating Positive Family Rituals" in the *Addiction Treatment Homework Planner* by Finley and Lenz); process the experience and redirect for conflict management.

31. List the ways in which a higher power can assist in recovery from family conflicts and addiction. (40)

40. Teach the client about the 12-step recovery group's concept of a higher power, and how this power can be used to assist in resolving family conflicts and addiction (e.g., attend worship services with family members, pray at meals, have family devotions where the family prays together).

32. Increase the level of independent functioning. (41, 42, 43)

41. Probe the client's fears surrounding emancipation; process these fears to resolution.

42. Confront the client's emotional dependence and his/her

avoidance of economic responsibility, which promote a continuing pattern of dependently living off of others.

43. Develop a structured written plan for the client's emancipation that includes steady employment, paying his/her own expenses, and independent housing.

33. Agree to continue to work on family conflict and addiction issues by regularly attending recovery groups and family therapy in aftercare. (44)

44. Help the client develop an aftercare program that includes regular attendance at recovery groups and the family therapy that is necessary to resolve family conflicts and maintain abstinence from addictive behavior.

34. Complete a survey to assess the degree of satisfaction with treatment. (45)

45. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.81	Conduct Disorder, Childhood-Onset Type
	313.81	Oppositional Defiant Disorder
	312.32	Conduct Disorder, Adolescent-Onset Type
	V61.20	Parent–Child Relational Problem
	V61.10	Partner Relational Problem
	V61.8	Sibling Relational Problem
	V71.01	Adult Antisocial Behavior
	_____	_____
	_____	_____

Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.32	F91.2	Conduct Disorder, Adolescent-Onset Type
313.81	F91.3	Oppositional Defiant Disorder
V61.20	Z62.820	Parent–Child Relational Problem
V61.10	Z63.0	Relationship Distress with Spouse or Intimate Partner
V61.8	Z62.891	Sibling Relational Problem
V71.01	Z72.811	Adult Antisocial Behavior
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.6	F60.7	Dependent Personality Disorder

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

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

GAMBLING

BEHAVIORAL DEFINITIONS

1. Reports a history of repeated unsuccessful attempts to stop or cut down on gambling, despite the verbalized desire to do so and the many negative consequences of continued gambling.
2. Denies that gambling is a problem, despite feedback from significant others that gambling is negatively affecting them and others.
3. Maintains a distorted belief that more gambling will certainly result in a financial windfall.
4. Experiences persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by gambling.
5. Has suspended important social, recreational, and/or occupational activities because they interfere with gambling.
6. Exhibits restlessness and irritability when attempting to stop gambling.
7. Reports frequent loss of time when gambling.
8. Demonstrates physical withdrawal symptoms (e.g., shaking, nausea, headaches, sweating, anxiety, insomnia, and/or depression) when going without gambling for any length of time.
9. Has a history of arrests for gambling-related offenses (e.g., bad checks, forgery, embezzlement, theft).
10. Invests large amounts of money, time, and activities to gamble.
11. Gambles greater amounts of money and for a longer time than intended.
12. Substance abuse accompanies gambling behavior.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over gambling and participate in a recovery-based program.
2. Accept the problem with gambling and begin to actively participate in a recovery program.
3. Withdraw from gambling emotionally and learn a new program of recovery, free from excessive stress and addictive behavior.
4. Acquire the necessary skills to maintain long-term abstinence from gambling.
5. Develop financial planning that will allow repayment of losses and established financial stability.

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SHORT-TERM OBJECTIVES

1. Provide honest and complete information regarding gambling history. (1)
2. Complete psychological testing or objective questionnaires for assessing problem gambling. (2)
3. Verbalize an increased knowledge of addiction and the process of recovery. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Complete a thorough family and personal biopsychosocial history that has a focus on the client's gambling.
2. Administer to the client psychological instruments designed to objectively assess problem gambling (e.g., Maroondah Assessment Profile for Problem Gambling; South Oaks Gambling Screen); give the client feedback regarding the results of the assessment.
3. Assign the client to attend a gambling didactic series to increase knowledge of the patterns and effects of gambling.

	4. Ask the client to identify several key points attained from attending each didactic; process these points.
	5. Teach the client about cross-tolerance (i.e., one drug or addictive behavior causes tolerance to develop for another); apply this to the client's situation (or assign "Understanding Nonchemical Addictions" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	6. Require the client to read *Gamblers Anonymous: A New Beginning* and gather five key points; process the points in session.
4. List 10 negative consequences resulting from or exacerbated by gambling. (7)	7. Ask the client to make a list of the ways gambling has negatively impacted his/her life (or assign *The Gambling Addiction Client Workbook* by Perkinson); process the list with the therapist or group.
5. Verbally admit to powerlessness over gambling. (8)	8. Assign the client to complete a Gamblers Anonymous (GA) Step 1 paper admitting to powerlessness over gambling behavior and any other addictions (or assign "Understanding Nonchemical Addictions" in the *Addiction Treatment Homework Planner* by Finley and Lenz), and present it in group therapy or to the therapist for feedback.
6. Verbalize a recognition that gambling was used as the primary coping mechanism to escape from stress or emotional pain, and resulted in negative consequences. (9, 10, 11)	9. Assess the client's history for depression, abuse, neglect, or other traumas that contribute to underlying emotional pain.
	10. Explore how gambling was used to escape from stress, emotional

pain, and/or boredom; highlight the negative consequences of this pattern of escapism.

11. Probe the client's sense of shame, guilt, and low self-worth that has resulted from gambling and its consequences.

7. Develop a list of the social, emotional, and family factors that contributed to gambling. (12)

12. Using the biopsychosocial history, assist the client in understanding the familial, emotional, and social factors that contributed to the development of problem gambling.

8. List 10 reasons to work on a plan for recovery from gambling. (13)

13. Assign the client to write a list of 10 reasons to be abstinent from gambling (or assign "Consequences and Benefits" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

9. List 10 lies used to hide gambling behavior. (14)

14. Help the client to see the dishonesty that goes along with gambling; have him/her list 10 lies he/she told to hide gambling, teaching the client why honesty is essential to recovery (or assign *The Gambling Addiction Client Workbook* by Perkinson).

10. Practice turning problems over to a higher power each day. (15, 16)

15. Teach the client about the GA concept of a higher power and how this can assist in recovery.

16. Using a GA Step 3 exercise, teach the client about the GA concept of *turning it over*, then assign turning over problems to a higher power each day; have the client record the event and discuss the results (or assign the client to complete the Step 3 exercise from the *Gambling Addiction Client Workbook* by Perkinson).

11. Acknowledge the abuse of mood-altering drugs and/or alcohol and the role substance abuse plays in gambling behavior. (17)	17. Explore the client's use and abuse of mood-altering drugs and alcohol; assess the role of substance abuse in reinforcing gambling behavior.
12. Identify and accept the need for treatment of a gambling problem. (18)	18. Conduct Motivational Interviewing to assess the client's stage of preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Problem and Pathological Gambling* by Whelan, Steenbergh, and Meyers).
13. Take prescribed medications as directed by the physician. (19)	19. Refer the client to a physician who will assess for the possible use of psychotropic medication for pathological gambling (e.g., antidepressants), monitor the effectiveness and side effects of medication, and make adjustments as needed.
14. Participate in individual or group therapy sessions focused on recovery from pathological gambling. (20, 21)	20. Refer to or conduct individual or group therapy using cognitive behavioral therapy with relapse prevention (see *Overcoming Pathological Gambling: Therapist Guide* by Ladouceur and Lachance; *A Cognitive Behavioural Therapy Programme for Problem Gambling: Therapist Manual* by Raylu and Oei).
	21. Assign the client reading consistent with the cognitive-behavioral treatment approach (e.g., *Overcoming Your Pathological Gambling: Workbook* by Ladouceur and Lachance).
15. Identify realistic goals for recovery. (22)	22. Discuss and request that the client write out basic treatment

expectations (e.g., personal changes, social changes, emotional needs) regarding recovery and process these with the clinician.

16. Discuss and record the kinds of actions one must engage in to recover from a gambling problem. (23)

23. Work collaboratively with the client to construct node-link maps that visually display the various actions, pathways, and consequences involved in gambling or refraining from gambling as a guide for directing his/her behavior and a reminder of what is likely to lead to gambling and its negative consequences; repeatedly refer to and review throughout therapy toward increasing the client's internalization of the content and adoption of the positive pathway (see *A Visual Representation System for Drug Abuse Counselors* by Dees, Dansereau, and Simpson).

17. Identify and make changes in social relationships that will support recovery. (24)

24. Review the negative influence of the client continuing his/her gambling-related friendships (gambling buddies), and assist him/her in making a plan to develop new relationships; revisit routinely and facilitate toward development of a new social support system (or assign "Creating Recovery Peer Support" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

18. Identify projects and other social and recreational activities that recovery will now afford and that will support recovery. (25, 26)

25. Assist the client in planning social and recreational activities that are free from association with gambling; revisit routinely and facilitate toward development of a new set of activities.

26. Plan household, work-related, and/or other free-time projects that can be accomplished to build the client's self-worth and self-concept without the practice of gambling.

19. Identify and foster the positive impact that sobriety will have on intimate and family relationships. (27)

27. Assist the client in identifying and facilitating the positive changes that will be made in family relationships during recovery.

20. Identify, challenge, and replace destructive self-talk and beliefs with alternative positives. (28, 29)

28. Use cognitive therapy approaches to explore the client's schema and self-talk that makes the client vulnerable to gambling and weakens his/her resolve to remain abstinent (e.g., misconceptions regarding probability and randomness, self-deprecation); challenge the biases; assist him/her in generating realistic self-talk that correct for the biases (see *Overcoming Your Pathological Gambling: Workbook* by Ladouceur and Lachance).

29. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success.

21. Learn and implement personal self-management and coping strategies to manage urges to lapse back into gambling. (30)

30. Teach client-tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence)

to manage triggered urges to gamble.

22. Participate in gradual repeated exposure to triggers of urges to lapse back into gambling within individual or group therapy sessions and between them; review with group members and therapist. (31, 32)

31. Direct and assist the client in construction of a hierarchy of urge-producing cue (or assign "Identifying Relapse Triggers and Cues" or "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

32. Select in vivo, role-played, and/or imaginal exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure; use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure; review with the client and group members, if done in group.

23. Learn and implement personal and interpersonal skills to manage common day-to-day challenges and build confidence in managing them without the use of gambling. (33, 34)

33. Assess current skill in managing common everyday personal and interpersonal stressors (e.g., work, social, family); use behavioral techniques (e.g., instruction, modeling, role-playing) to build tailored problem-solving, social, and/or communication skills to manage the challenges of recovery from pathological gambling.

34. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

24. Implement relapse prevention strategies for managing possible future situations with high risk for relapse. (35, 36, 37, 38)

35. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

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

37. Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for gambling and/or substance abuse (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner* by Jongsma).

38. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner* by Jongsma).

25. Family members decrease the frequency of enabling the gambler after verbally identifying their enabling behaviors. (39)

39. Monitor the client's family for enabling behaviors; assist the client's family members in implementing consistent techniques facilitative of the client's recovery.

26. Complete a survey to assess the degree of satisfaction with treatment. (40)

40. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.81	Conduct Disorder, Childhood-Onset Type
	312.31	Pathological Gambling
	312.30	Impulse-Control Disorder NOS
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.82	F91.2	Conduct Disorder, Adolescent-Onset Type
312.31	F63.0	Gambling Disorder
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder

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

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

GRIEF/LOSS UNRESOLVED

BEHAVIORAL DEFINITIONS

1. Presents with unresolved bereavement, intense longing for the significant other, and engaging in addictive behavior to cope with grief.
2. Reports constant thoughts of the lost loved one, to the point of inability to move forward in life.
3. Verbalizes excessive and unreasonable feelings of responsibility for the loss of a significant other, including believing that he/she did not do enough to prevent the person's death.
4. Expresses feelings of guilt about being a survivor when loved ones have died.
5. Lacks ability to talk about the death of a loved one on anything more than a superficial level.
6. Demonstrates vegetative symptoms of depression (e.g., lack of appetite, weight loss, sleep disturbance, anhedonia, lack of energy).
7. Talking or thinking about the deceased loved one results in overwhelming sadness.
8. Has thoughts of suicide to relieve the pain and join the significant other.

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LONG-TERM GOALS

1. Resolve feelings of anger, sadness, guilt, and/or abandonment surrounding the loss of the loved one, and make plans for the future.
2. Accept the loss of the loved one and increase social contact with others.

3. Develop coping skills to help renew old relationships and make new ones.
4. Maintain a program of recovery free from addiction and unresolved grief.

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SHORT-TERM OBJECTIVES

1. Tell the story of the lost relationship. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing the depth of grief. (3)

3. Discuss the positive and negative aspects of the lost relationship. (4)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share the entire story of the relationship with the lost person, possibly using pictures or mementos connected to the deceased loved one.
2. Ask the client to elaborate in a written autobiography the circumstances, feelings, and effects of the loss or losses in his/her life.

3. Administer to the client psychological instruments designed to objectively assess the depth of grief and depression (e.g., Beck Depression Inventory—II, Grief Experience Inventory); give the client feedback regarding the results of the assessment and retest if necessary to assess progress in treatment.

4. Help the client to see both the positive and negative aspects of the lost relationship, keeping him/her from overidealizing the relationship.

4. Read books on the topic of grief to better understand the loss experience and to increase a sense of hope. (5, 6)

5. Ask the client to read books on grief and loss (e.g., *Getting to the Other Side of Grief: Overcoming the Loss of a Spouse* by Zonnebelt-Smeenge and DeVries; *How Can It Be All Right When Everything Is All Wrong?* by Smedes; *How to Survive the Loss of a Love* by Colgrove, Bloomfield, and McWilliams; or *Good Grief* by Westberg); process the content.

6. Ask the parents of a deceased child to read a book on coping with their loss (e.g., *When the Bough Breaks: Forever After the Death of a Son or Daughter* by Bernstein); process the key themes gleaned from the reading.

5. Identify what stages of grief have been experienced along the continuum of the grieving process. (7, 8)

7. Educate the client on the stages of the grieving process and answer any questions he/she may have.

8. Assist the client in identifying the stages of grief that he/she has experienced and which stage he/she is presently working through.

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. (9, 10, 11, 12)

9. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
11. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
12. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

7. Verbalize the scope of emotional reaction felt because of the loss. (13)

13. Help the client identify the breadth of feelings, behaviors, and thoughts experienced due to the loss (e.g., hurt, loss, abandonment, anger, social withdrawal, sleeplessness); discuss the process of letting go of a loved one (or assign "Am I Having Difficulty Letting Go?" in the *Addiction Treatment*

	Homework Planner by Finley and Lenz); assess if the client's symptom pattern meets the criteria for major depression (see the "Unipolar Depression" chapter in this *Planner*).
8. Verbalize how the loss of the loved one led to addiction in order to avoid painful feelings. (14, 15)	14. Teach the client how the loss of the loved one led to addiction so as to cope with the pain. 15. Teach the client how chemical use has led to an avoidance of working through the loss.
9. List five negative consequences that resulted from using addiction to cope with grief and loss. (16)	16. Assist the client in identifying at least five ways that engaging in substance use to cope with loss has led to more pain, troubles, and unresolved feelings.
10. Verbalize a resolution of guilt about the loss. (17, 18)	17. Explore the client's feelings of guilt and blame surrounding the loss (or assign the client to read *The Grief Recovery Handbook* by James and Friedman). 18. Using logic and reasoning, help the client to see that he/she is not responsible for the loss.
11. Terminate the blame of others for the loss. (19)	19. Teach the client about the destructive consequences of holding on to anger and blaming others for the loss.
12. Verbalize an understanding of how dependence on the lost person and dependence on addictive behavior are similar. (20)	20. Help the client to see the common elements in the dependence on the deceased individual and on addictive behavior; process how both are unhealthy.
13. Express thoughts and feelings about the deceased that went unexpressed while the deceased was alive. (21, 22, 23)	21. Conduct an empty chair exercise with the client, where he/she focuses on expressing to the lost loved one, imagined in the chair, what he/she never said while that loved one was alive.

22. Assign the client to visit the grave of the loved one to talk to the deceased and vent his/her feelings.

23. Ask the client to write a letter to the lost person describing his/her fond memories, painful and/or regretful memories, and how he/she currently feels (or assign "Dear _____: A Letter to a Lost Loved One" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the letter in session.

14. Make a written plan to increase independence and social interaction. (24, 25)

24. Help the client make a written plan to help him/her live a more active and independent life (e.g., make plans for social life, hobbies, financial security, job, recovery, contact sponsor, a grief group, a singles' group).

25. Assign the client to write a plan to improve social contact with old friends and to make new ones (or assign "Moving On After Loss" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

15. Attend a grief/loss support group. (26)

26. Ask the client to attend a grief/loss support group and report to the therapist how he/she felt about attending.

16. List ways in which a higher power can assist in recovery from grief and addiction. (27, 28, 29)

27. Teach the client about the 12-step recovery program's concept of a higher power, and help him/her to see how this can assist in recovery from grief and addiction (e.g., talk to the higher power about the grief/loss, imagine the higher power healing the pain, ask the higher power to direct you to other friends and family who can provide support).

28. Assign the client to read page 417 in the Alcoholics Anonymous *Big Book*, and discuss how the implications of this content about a higher power relates to loss.
29. Using a 12-step recovery program's Step 11 exercise, teach the client how to pray and meditate; then assign the client to contact his/her higher power each day about his/her grief.

17. Begin attending a 12-step recovery group and make contact with a sponsor and share plans for recovery. (30, 31)

30. Teach the client about the importance of regularly attending an addiction recovery group, getting a sponsor, and helping others in recovery.
31. Assign the client to make contact with a 12-step recovery program's temporary sponsor and discuss recovery plans.

18. Identify the positive characteristics of the deceased loved one, the positive aspects of the relationship with the deceased loved one, and how these things may be remembered. (32, 33)

32. Ask the client to list the most positive aspects of and memories about his/her relationship with the lost loved one; explore the client's perception of how the deceased would encourage him/her to face the future (or assign "What Would They Want for Me?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
33. Assist the client in developing rituals (e.g., placing memoriam in newspaper on anniversary of death, volunteering time to a favorite cause of the deceased person) that will celebrate the memorable aspects of the loved one and his/her life.

19. Encourage at least one person in recovery each day. (34)

34. To improve self-worth and self-esteem, assign the client to encourage one person in recovery each day.

20. Develop a written aftercare plan to resolve addiction and grief. (35)

21. Family members verbalize a connection between unresolved grief/loss and addictive behavior. (36, 37)

22. Complete a survey to assess the degree of satisfaction with treatment. (38)

35. Help the client to develop a written aftercare plan that specifically outlines a recovery plan such as attending 12-step recovery program meetings, aftercare sessions, continued therapy, contacting sponsor, turning it over daily, prayer and meditation (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

36. Discuss with family members the connection between grief and addictive behavior.

37. In a family session, review what each member can do to assist the client in recovery.

38. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	311	Depressive Disorder NOS
	308.3	Acute Stress Disorder
	V62.82	Bereavement
	309.0	Adjustment Disorder With Depressed Mood
	309.3	Adjustment Disorder With Disturbance of Conduct

309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
311	F32.9	Unspecified Depressive Disorder
308.3	F43.0	Acute Stress Disorder
V62.82	Z63.4	Uncomplicated Bereavement
309.0	F43.21	Adjustment Disorder, With Depressed Mood
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
309.28	F43.23	Adjustment Disorder, With Mixed Anxiety and Depressed Mood
309.4	F43.25	Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct

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

IMPULSIVITY

BEHAVIORAL DEFINITIONS

1. Exhibits a tendency to act too quickly on impulses without careful thought or planning, resulting in numerous negative consequences.
2. Demonstrates difficulty with patience, particularly while waiting for someone or waiting in line.
3. Impulsivity facilitates a self-defeating pattern of addiction behavior.
4. Reports loss of control overaggressive impulses, resulting in assault, self-destructive behavior, and/or damage to property.
5. Desires everything immediately—demonstrates a decreased ability to delay pleasure or gratification.
6. Has a history of acting out in at least two areas that are potentially self-damaging (e.g., spending money, sexual activity, reckless driving, addiction).
7. Overreacts to mildly aversive or pleasure-oriented stimulation.
8. Experiences a sense of tension or affective arousal before engaging in the impulsive behavior (e.g., kleptomania or pyromania).
9. Senses pleasure, gratification, or release at the time of committing an antisocial act.

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LONG-TERM GOALS

1. Maintain a program of recovery, free from impulsive behavior and addiction.

2. Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.
3. Learn the techniques necessary to decrease impulsive thoughts, feelings, and behaviors, and develop a program of recovery consistent with thoughtful behavior and abstinence.
4. Learn to stop, think, and plan before acting.
5. Decrease antisocial behaviors and practice prosocial behaviors.

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SHORT-TERM OBJECTIVES

1. Verbalize an understanding of the powerlessness and unmanageability that results from impulsivity and addiction. (1)

2. Verbalize specific instances of the negative consequences of impulsivity and addiction. (2)

3. Complete psychological testing or objective questionnaires for assessing impulsivity. (3)

THERAPEUTIC INTERVENTIONS

1. Help the client to understand how impulsivity and addictive behavior led to powerlessness and unmanageability (or assign the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Review the client's behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity (or assign "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).

3. Administer to the client psychological instruments designed to objectively assess impulsivity (e.g., Barratt Impulsiveness Scale-11, Conners' Adult ADHD Rating Scales); give the client feedback regarding the results of the

assessment and test again, if necessary, to assess treatment progress.

4. Discuss how impulsivity and addiction meet the 12-step recovery program's criteria for *insanity*. (4)

4. Help the client to see that doing the same things over and over again and expecting different results meets the 12-step recovery program's definition of *insanity* (or assign the Step 2 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

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. (5, 6, 7, 8)

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and

	factors that could offer a better understanding of the client's behavior.
	8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
6. List the negative consequences that are caused by impulsivity. (9, 10, 11)	9. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others resulting from it.
	10. Assign the client to write a list of negative consequences that occurred because of impulsivity (or assign "Recognizing the Negative Consequences of Impulsive Behavior" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	11. Ask the client to identify two of the most destructive consequences of his/her impulsive behavior; discuss alternative behaviors that could have avoided such destructive consequences.
7. Verbally identify several times when impulsive action led to addictive behavior and subsequent negative consequences. (12)	12. Explore times when the client acted too quickly on impulses, resulting in addictive behavior that only added to the negative consequences.

8. Increase the frequency of previewing behavioral decisions with a trusted friend or family member for feedback regarding consequences before the decision is enacted. (13, 14)

13. Conduct a session with spouse, significant other, sponsor, or family member and client to develop a plan for giving constructive advice prior to the client engaging in impulsive acts.

14. Review the client's implementation of previewing with significant others decisions to act before engaging in impulsive actions; reinforce success and redirect for failure.

9. Verbalize the biopsychosocial elements that cause or exacerbate impulsivity and addictive behavior. (15)

15. Probe the client's biopsychosocial history and help the client to see the contributing factors to his/her impulsivity and addictive behavior (e.g., family models of impulsivity or addictive behavior, anxiety that energizes impulsivity, failure to learn delay of gratification in childhood) (or assign "Understanding Family History" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

10. Comply with a physician's evaluation regarding the necessity for psychopharmacological intervention. (16)

16. Refer the client to a physician to examine him/her, order medications as indicated, titrate medications, and monitor for side effects and effectiveness.

11. Take all medications as prescribed and report as to effectiveness and side effects. (17, 18)

17. Arrange for medications to be taken as ordered by the physician.

18. Monitor the client's psychotropic medication for effectiveness as well as side effects.

12. Identify the thoughts that trigger impulsive behavior, and then replace each thought with a thought that is more accurate. (19, 20)

19. Help the client to uncover dysfunctional thoughts that lead to impulsivity; assist him/her in replacing each dysfunctional thought with a thought that is more accurate, positive,

	self-enhancing, and adaptive (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	20. Help the client to develop a list of positive, accurate, self-enhancing thoughts to read to himself/herself each day, particularly when feeling upset, anxious, or uncomfortable (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
13. List the impulsive behaviors that are displayed when feeling anxious and uncomfortable, and replace each behavior with an action that is positive and adaptive. (21)	21. Probe the client's anxious, impulsive behaviors, and then use modeling, role-playing, and behavior rehearsal to teach him/her new behaviors that are positive and adaptive such as talking to someone about the problem, taking a time-out, calling the sponsor, going to a meeting, exercising, or relaxing (or assign "Learning to Think Things Through" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
14. Implement relaxation procedures when feeling upset or uncomfortable. (22)	22. Teach the client relaxation techniques such as progressive relaxation, self-hypnosis, or biofeedback (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay); assign him/her to relax whenever he/she feels uncomfortable (or assign the "Self-Soothing: Calm Down, Slow Down" exercise from the *Addiction Treatment Homework Planner* by Finley and Lenz).
15. Practice stopping, looking, listening, thinking, and planning before acting. (23, 24)	23. Using modeling, role-playing, and behavior rehearsal, show the client how to use "stop, look,

listen, think, and plan before acting" in various current situations (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma).

24. Review the client's use of "stop, look, listen, think, and plan" or other means to control impulsivity in day-to-day living, and identify the positive consequences (recommend *Overcoming Impulse Control Problems* by Grant, Donahue, and Odlaug).

16. Verbalize an understanding of how Step 3 of Alcoholics Anonymous can be used in recovery from impulsivity and addiction. (25, 26)

25. Teach the client about the 12-step recovery program's concept of a higher power, and discuss how he/she can use a higher power effectively in recovery (e.g., practice stopping and asking a higher power for strength and direction, practice daily prayer and meditation).

26. Teach the client how to turn his/her will and life over to the care of a higher power (or assign the Step 3 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

17. Relate how each dysfunctional behavior identified in a 12-step recovery program's Step 4 exercise can be related to impulsivity and addiction. (27, 28)

27. Using a 12-step recovery program's Step 4 exercise, assign the client to write an autobiography of the exact nature of his/her wrongs, and relate these wrongs to impulsivity and addictive behavior.

28. Assist the client in acknowledging the relationship between the wrongful behaviors identified in a Step 4 exercise and his/her impulsivity and addictive behavior.

18. Develop and write a continuing care program that includes the recovery group meetings and any further therapy that is necessary for recovery. (29)

19. Family members verbalize a connection between impulsivity and addictive behavior. (30, 31, 32)

20. Complete a survey to assess the degree of satisfaction with treatment. (33)

29. Help the client to develop an aftercare plan that includes regular recovery groups, use of learned coping techniques, getting a sponsor, and any further therapy necessary to recover from impulsivity and addiction (or assign "Handling Crisis" from the *Addiction Treatment Homework Planner* by Finley and Lenz).

30. Encourage the client to share with family members the journey through impulsivity, addiction, and recovery.

31. Discuss with family members the connection between impulsive behavior and addictive behavior.

32. In a family session, review what each member can do to assist the client in recovery.

33. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	296.4x	Bipolar I Disorder, Most Recent Episode, Manic

	301.13	Cyclothymic Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	314	Attention-Deficit/Hyperactivity Disorder
	321.30	Impulse-Control Disorder NOS
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.8	F91.x	Conduct Disorder
313.81	F91.3	Oppositional Defiant Disorder
296.xx	F31.1x	Bipolar I Disorder, Manic
301.13	F34.0	Cyclothymic Disorder
296.89	F31.81	Bipolar II Disorder
312.34	F63.81	Intermittent Explosive Disorder
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

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

LEGAL PROBLEMS

BEHAVIORAL DEFINITIONS

1. Presents with legal charges pending adjudication.
2. Has a history of repeated violations of the law, many occurring while under the influence of drugs or alcohol.
3. Unresolved legal problems are complicating recovery from addiction.
4. Expresses fear of the legal system adjudicating current problems.
5. Has a history of repeated violations of the law related to buying, selling, or using illegal substances.
6. Is under a court order to seek treatment for addiction.
7. Expresses feelings of anger, resentment, and fear of abandonment associated with impending divorce.
8. Chemical dependency has resulted in several arrests.
9. Fears loss of freedom due to current legal charges.

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LONG-TERM GOALS

1. Maintain a program of recovery free from addiction and legal conflicts.
2. Accept the responsibility for legal problems without blaming others.
3. Consult with legal authorities (e.g., attorney, probation officer, police, court official) to make plans for adjudicating legal conflicts.
4. Understand the need to maintain abstinence to remain free of negative consequences, which include legal problems.
5. Decrease antisocial behaviors and increase prosocial behaviors.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that results from legal conflicts and addiction. (1)
2. Identify the nature and history of legal problems. (2)
3. Complete psychological testing or objective questionnaires for assessing antisocial traits and propensity for illegal behavior. (3)
4. Verbalize an acceptance of the responsibility for addiction and legal problems without blaming others. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Help the client to understand the relationship between addictive behavior and legal conflicts, and how these problems result in powerlessness and unmanageability.
2. Gather a history of the client's illegal behavior and his/her experience with the legal system.
3. Administer to the client psychological instruments designed to objectively assess antisocial traits and propensity for illegal behavior (e.g., Millon Clinical Multiaxial Inventory—III, Jesness Behavior Checklist); give the client feedback regarding the results of the assessment and repeat testing if necessary to assess progress in treatment.
4. Help the client to identify and accept responsibility for the decisions that he/she made that resulted in addiction and legal problems without blaming others (or assign "Handling Tough Situations in a Healthy Way" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)

5. Confront the client for avoidance of his/her responsibility for legal problems (or assign "Accept Responsibility for Illegal Behavior" in the *Adult Psychotherapy Homework Planner* by Jongsma).
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. Acknowledge the connection between legal problems and addictive behavior. (10, 11)

10. Teach the client the relationship between his/her legal problems and his/her addictive behavior (or assign "Handling Tough Situations in a Healthy Way" and/or "What's Addiction Got to Do With My Problems?" in the *Addiction Treatment Homework Planner* by Finley and Lenz); solicit the client's acknowledgement of this relationship.

11. Assign the client to write how each legal conflict has been related to addictive behavior.

7. Write a plan that outlines the changes needed in behavior, attitude, and associations to protect self from harmful legal consequences. (12)

12. Teach the client the difference between antisocial and prosocial behaviors, helping to identify his/her antisocial behaviors and attitudes; help develop prosocial plans for changes to be made in recovery (e.g., respect for the law, helping others, honesty, reliability, regular attendance at work, recovery groups, aftercare, halfway house).

8. Replace inaccurate self-defeating thoughts with realistic, positive cognitions. (13, 14, 15)

13. Probe the client's inaccurate self-defeating thoughts and feelings that surround addictive behavior and legal problems.

14. Teach the client about criminal thinking (e.g., rationalization, denial, superoptimism, blaming others); assist him/her in identifying his/her criminal thinking, correcting each criminal thought with a thought that is honest and respectful of others.

15. Assist the client in identifying positive, realistic thoughts to replace dysfunctional thinking that leads to addictive and illegal behaviors (or assign "Crooked Thinking Leads to Crooked Behavior" in the *Adult Psychotherapy Homework Planner* by Jongsma).

9. Meet with an attorney to make plans for resolving legal conflicts. (16)

16. Encourage and facilitate the client to meet with an attorney to discuss plans for resolving legal conflicts.

10. Contact the probation or parole officer and agree in writing to meet the conditions of probation or parole. (17)

17. Encourage and facilitate the client to meet with his/her probation or parole officer, and assign him/her to agree in writing to meet all conditions of probation or parole.

11. Verbalize ways to meet social, emotional, and financial needs in recovery without illegal activity or addiction. (18)

18. Help the client to develop a plan to meet social, emotional, and financial needs in recovery without resorting to criminal activity or addictive behavior.

12. Verbalize the importance of obeying the laws of society to maintain abstinence and work through a program of recovery. (19)

19. Help the client to understand why he/she needs to obey the law in order to maintain abstinence from addictive behavior (e.g., lower stress, better peer group, improved self-esteem, etc.).

13. Replace self-serving behavior with acts of kindness toward helping others. (20)

20. Help the client to understand the importance of helping others in recovery in order to replace a criminal attitude of taking and

	entitlement with an attitude of giving and self-sacrifice.
14. Verbalize the importance of a higher power in recovery, and list five ways in which a higher power can assist in recovery. (21)	21. Teach the client about the 12-step recovery program's concept of a higher power and how a higher power can assist in recovery from legal conflicts and addiction (e.g., practice trusting a higher power to help with legal problems, practice daily prayer and meditation).
15. Develop an aftercare program that includes regular attendance at recovery groups and any other necessary therapy. (22)	22. Help the client to develop an aftercare program that has all of the elements necessary to maintain abstinence and resolve legal conflicts (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
16. Verbalize the importance of resolving legal issues honestly. (23)	23. Help the client to understand the importance of resolving legal conflicts honestly and legally; teach that honesty is the basis for trust.
17. Family members verbalize what each can do to assist the client in recovery. (24, 25)	24. Discuss with family members the connection between legal problems and addictive behavior. 25. In a family session, review what each member can do to assist the client in recovery.
18. Complete a survey to assess the degree of satisfaction with treatment. (26)	26. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.8	Conduct Disorder
	313.81	Oppositional Defiant Disorder
	309.3	Adjustment Disorder With Disturbance of Conduct
	312.34	Intermittent Explosive Disorder
	V71.01	Adult Antisocial Behavior
	_____	_____
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Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.8	F91.x	Conduct Disorder
313.81	F91.3	Oppositional Defiant Disorder
309.3	F43.24	Adjustment Disorder With Disturbance of Conduct
312.34	F63.81	Intermittent Explosive Disorder
V71.01	Z72.811	Adult Antisocial Behavior
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

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

LIVING ENVIRONMENT DEFICIENCY

BEHAVIORAL DEFINITIONS

1. Lives in an environment in which there is a high risk for relapse.
2. Lives with an individual who is a regular user/abuser of alcohol and/or drugs.
3. Experiencing significant social isolation, withdrawal from social life.
4. Lives in an environment in which there is a high risk of physical, sexual, or emotional abuse.
5. Has many friends or relatives who are criminal or addicted.
6. Reports that family is angry or negative toward the addict and not supportive of a recovery program.
7. Presents as financially destitute and in need of assistance for adequate food and shelter.
8. Associates with peer group members who are regular users/abusers of alcohol and/or drugs.
9. Lives in a neighborhood that has a high incidence of alcohol and drug addiction, as well as crime.

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LONG-TERM GOALS

1. Maintain a program of recovery free from addiction and the negative impact of the deficient environment.
2. Improve the social, occupational, financial, and living situation sufficiently to increase the probability of a successful recovery from addiction.

3. Understand the negative impact of the current environment on addiction recovery.
4. Develop a peer group that is supportive of recovery.
5. Family members support the client's recovery.
6. Accept the importance of working a program of recovery that necessitates attendance at recovery groups and helping others.

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SHORT-TERM OBJECTIVES

1. Verbalize the sense of powerlessness and unmanageability that results from a deficient environment and addiction. (1)

2. Identify specific living environment problems and how they negatively affect recovery. (2, 3)

3. Complete psychological testing or objective questionnaires for assessing perception of social and family environment. (4)

THERAPEUTIC INTERVENTIONS

1. Help the client to see the powerlessness and unmanageability that results from addiction and a deficient environment (or assign the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Help the client identify problems with his/her living environment and the negative impact that they have on recovery.

3. Help the client to list specific instances when the high-risk social and/or family environment led to negative consequences and addiction (or assign the "Understanding Family History" exercise from the *Addiction Treatment Homework Planner* by Finley and Lenz).

4. Administer to the client psychological instruments designed to objectively assess the client's perception of his/her social and family environment (e.g., Quality

of Life Inventory, Family Environment Scale); give the client feedback regarding the results of the assessment and repeat testing if necessary to assess progress in treatment.

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

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the

	client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Make a written plan to address each living environment problem in recovery. (9)	9. Help the client to develop a written plan for addressing each living environment problem in recovery.
6. List the positive and negative consequences of continuing to live in the current high-risk environment. (10)	10. Discuss the alternatives that are available for moving out of the current living situation, which promotes ongoing addiction.
7. Identify current social, occupational, and financial needs, and make a plan to meet each need in recovery. (11, 12)	11. Help the client to identify his/her social, occupational, and financial needs, and make a written plan to meet each need in recovery (or assign "Assessing My Needs" in the *Addiction Treatment Homework Planner* by Finley and Lenz). 12. Teach the importance of a supportive peer group, and assign the client to list 10 reasons why he/she needs a new peer group to maintain abstinence.
8. Write a personal recovery plan detailing the recovery groups, aftercare, social relationships, and further treatment that will be needed in recovery. (13, 14, 15, 16)	13. Facilitate the client meeting with a 12-step recovery program contact person, and encourage him/her to discuss recovery plans. 14. Help the client to develop a personal recovery plan that has all of the elements necessary to recover from addictive behavior

	and the deficient living environment (or assign "What Would My Ideal Life Look Like?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	15. Encourage the client's attendance at 12-step recovery program meetings as a means of developing a supportive peer group.
	16. Assign the client to write at least five steps that he/she will take to initiate new relationships with recovering people.
9. Implement turning over to a higher power the living environmental problems and the urge to engage in addictive behavior. (17, 18, 19)	17. Teach the client about the 12-step recovery program's concept of a higher power, and show him/her how a higher power can assist in recovery (e.g., by learning how to turn problems over to a higher power, practicing regular prayer and meditation).
	18. Using a 12-step recovery program's Step 3 exercise, teach the client how to turn his/her will and life over to a higher power (or assign the client to complete the Step 2 and Step 3 exercises in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
	19. Monitor the client's implementation of a 12-step recovery program's Step 3 exercise; reinforce his/her success and redirect for failure.
10. Verbalize a plan to continue spiritual growth within a community of believers. (20)	20. Assist the client in developing a plan to continue his/her spiritual growth (e.g., church, recovery groups, counseling, meeting with a pastor, spiritual reading material).

11. Practice saying no to addictive and antisocial behavior in high-risk situations. (21, 22, 23, 24)

21. Using modeling, role-playing, and behavior rehearsal, teach the client refusal to engage in addictive behavior, then practice refusal in the high-risk situations for relapse (e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, and testing personal control).

22. Using a 12-step recovery program's Step 4 inventory, assign the client to write an autobiography detailing the exact nature of his/her addiction-related problem behaviors, and how these relate to the negative peer group and addictive behavior (recommend *Coping With Peer Pressure* by Kaplan).

23. Clarify the distinction between passive, aggressive, and assertive behavior.

24. Have the client role-play assertive responses to situations he/she is currently facing in his/her life; assign the client to practice assertive expression of feelings, thoughts, and desires to others during the week (recommend *Your Perfect Right* by Alberti and Emmons).

12. Write a letter to each significant other, discussing problems with the living environment, and share plans for recovery. (25, 26)

25. Help the client to write a letter to each significant other sharing his/her problem with addiction, how the living environment has fostered the addiction, and the plan for recovery.

26. Meet with family members to teach them about addiction, discuss the living environment deficiencies, and make plans for support of the client's recovery.

13. Develop a written plan as to how to react to family members who are addicted. (27)
14. Family members verbalize what each can do to assist the client in recovery. (28, 29)
15. Complete a survey to assess the degree of satisfaction with treatment. (30)

27. Help the client to develop a plan as to how to deal with family members who are addicted.
28. Discuss with family members the connection between living environment deficiencies and addictive behavior.
29. In a family session, review what each member can do to assist the client in recovery.
30. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	V61.20	Parent–Child Relational Problem
	V61.10	Partner Relational Problem
	V61.8	Sibling Relational Problem
	V62.81	Relational Problem NOS
	V61.22	Physical Abuse of Child
	V61.22	Sexual Abuse of Child
	V61.21	Neglect of Child
	V61.12	Physical Abuse of Adult
	V61.12	Sexual Abuse of Adult
	V62.20	Occupational Problem
	995.54	Physical Abuse of Child (Victim)
	995.52	Neglect of Child (Victim)
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
V61.20	Z62.820	Parent–Child Relational Problem
V61.10	Z63.0	Relationship Distress With Spouse or Intimate Partner
V61.8	Z62.891	Sibling Relational Problem
V61.22	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Abuse
V62.83	Z69.021	Encounter for Mental Health Services for Perpetrator of Nonparental Child Abuse
V61.22	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Sexual Abuse
V62.83	Z69.021	Encounter for Mental Health Services for Perpetrator of Nonparental Child Sexual Abuse
V61.21	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Neglect
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Sexual
V62.83	Z69.82	Encounter for Mental Health Services for Perpetrator of Nonspousal Adult Abuse
V62.29	Z56.9	Other Problem Related to Employment
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
995.52	T74.02XA	Child Neglect, Confirmed, Initial Encounter
995.52	T74.02XD	Child Neglect, Confirmed, Subsequent Encounter

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MEDICAL ISSUES

BEHAVIORAL DEFINITIONS

1. Has been diagnosed with medical problems that complicate recovery from addiction.
2. Presents with medical problems that require medical monitoring of medications or assistance with mobility.
3. Has organic brain syndrome that compromises learning, as a result of use of mood-altering chemicals.
4. Demonstrates inability to self-administer prescribed medications.
5. Suffers from chronic pain syndrome, which places the client at high risk for relapse.
6. Has medical problems that require medical/nursing assistance.
7. Self-medicates medical problems through use of mood-altering chemicals.
8. Reports negative emotions concerning medical illness that led to addiction.
9. Demonstrates a compromised ability to concentrate on recovery due to the severity of medical problems.
10. Blames substance abuse on medical issues and denies a primary substance abuse disorder.
11. Doctor shops in order to obtain the medication necessary to reduce symptoms.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and the negative effects of medical issues.
2. Resolve medical problems and return to a normal level of functioning.
3. Understand the relationship between medical issues and addiction.
4. Reduce the impact of medical problems on recovery and relapse potential.
5. Improve coping skills with organic brain syndrome, to allow for a self-directed program of recovery.
6. Understand and participate in the medical management of physical health problems.
7. Contact all prescribing medical personnel and inform them of the patient's doctor shopping and addiction.

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SHORT-TERM OBJECTIVES

1. Verbalize an acceptance of the powerlessness and unmanageability that results from using addictive behavior to cope with medical problems. (1)

2. Identify medical problems and how these relate to addiction. (2)

THERAPEUTIC INTERVENTIONS

1. Help the client see the powerlessness and unmanageability that result from medical issues and addiction (or assign the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Explore the client's medical history and help him/her to see the relationship between his/her medical problems and addictive behavior (or assign "Coping With Addiction and Other Medical Problems" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

3. Complete psychological testing or objective questionnaires for assessing coping with medical problems. (3)	3. Administer to the client psychological instruments designed to objectively assess coping with medical problems (e.g., Beck Depression Inventory—FastScreen for Medical Patients; Coping With Health, Injuries, and Problems); give the client feedback regarding the results of the assessment and repeat testing if necessary to assess progress in treatment.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)	4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change). 5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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). 6. Assess for any issues of age, gender, or culture that could

	help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
	7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Verbalize an acceptance of the seriousness of medical problems and addictive behavior. (8)	8. Teach the client about medical issues and addiction, and how each of these illnesses poses a serious risk to his/her welfare.
6. List the negative consequences that resulted from using addiction to cope with medical problems. (9, 10)	9. Help the client to develop a list of negative consequences that occurred because of using addictive behavior to cope with medical problems (or assign "Coping With Addiction and Other Medical Problems" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	10. Educate the client regarding the negative impact of addictive behavior on bodily functioning and systems.
7. Visit with a physician for examination of the medical condition and addiction, and cooperate with treatment plan. (11, 12)	11. Physician to examine the client and make recommendations as indicated to treat the medical condition and alleviate symptoms.

12. Monitor the client's compliance with the treatment plan as ordered by the physician; redirect the client as needed.

8. Verbalize an understanding of the medical condition, the treatment options, and prognosis. (13, 14, 15, 16)

13. Help the client to understand his/her medical problem and the need to cooperate with medical management.

14. Provide the client with references to literature of other informational resources regarding his/her medical condition.

15. Facilitate the medical personnel's teaching the client about his/her medical condition and discussing the treatment plan and prognosis.

16. Help the client to understand the importance of medical management and follow-up in aftercare.

9. Participate in decisions regarding the medical management of biomedical problems. (17)

17. Teach the client assertiveness skills, and encourage the implementation of assertiveness in obtaining information about and becoming involved in the management of his/her medical treatment (or assign "How I Feel About My Medical Treatment" in the *Adult Psychotherapy Homework Planner* by Jongsma).

10. List 10 things to do to improve physical functioning. (18)

18. After consultation with the medical staff, help the client to list 10 actions that he/she can take to improve physical functioning (e.g., take medications; maintain abstinence; practice relaxation; implement proper diet, rest, and exercise; keep regular follow-up appointments with the physician).

11. Implement relaxation exercises as a pain management technique. (19)

19. Teach the client relaxation techniques to manage chronic pain (or assign the "Self-Soothing: Calm Down, Slow Down" exercise from the *Addiction Treatment Homework Planner* by Finley and Lenz).

12. Accept and follow through on a referral to a pain management clinic. (20)

20. Refer the client to a pain clinic for medical and psychological management of pain (see the "Chronic Pain" chapter in this *Planner*).

13. Discuss with family members the medical problems and addiction, and make plans for family members to obtain supportive services. (21)

21. In a family session, discuss the medical issues and addiction, and make recommendations for family members to obtain supportive services such as Al-Anon, Alateen, or a medical support group.

14. List ways in which a higher power can assist in recovery from medical issues and addictive behavior. (22, 23)

22. Teach the client the 12-step recovery program's concept of a higher power, and help him/her to see how a higher power can be helpful in recovery (e.g., pray for assistance with medical problems, practice regular meditation, attend religious activities to gain support).

23. Teach the client how prayer and meditation can be used in daily recovery (or assign the client to complete the Step 11 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

15. Write a personal recovery plan that includes regular attendance at recovery groups and any medical treatment necessary to control medical issues and addiction. (24)

24. Help the client to develop a personal recovery plan that details what he/she is going to do in recovery to remain abstinent and to treat biomedical issues, such as attend recovery groups regularly, make medical visits regularly, take medication as

indicated, get a sponsor, attend aftercare, help others (or assign "Physical and Emotional Self-Care" or "Managing Pain Without Addictive Drugs" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

16. Family members verbalize what each can do to assist the client in recovery. (25, 26)

25. Discuss with family members the connection between the client's medical issues and his/her addictive behavior; review the steps that the client must take to recover successfully.

26. In a family session, review what each member can do to assist the client in recovery.

17. Complete a survey to assess the degree of satisfaction with treatment. (27)

27. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.89	Pain Disorder Associated With Psychological Factors and Axis III Disorder
	307.80	Pain Disorder Associated With Psychological Factors
	300.7	Hypochondriasis
	300.81	Somatization Disorder
	316	Personality Traits Affecting (Axis III Disorder)
	316	Maladaptive Health Behaviors Affecting (Axis III Disorder)

316	Psychological Symptoms Affecting (Axis III Disorder)
294.9	Cognitive Disorder NOS
309.24	Adjustment Disorder With Anxiety
309.0	Adjustment Disorder With Depressed Mood
309.3	Adjustment Disorder With Disturbance of Conduct
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.89	F54	Psychological Factors Affecting Other Medical Conditions
307.80	F45.1	Somatic Symptom Disorder With Predominant Pain
300.7	F45.21	Illness Anxiety Disorder
300.81	F45.1	Somatic Symptom Disorder
316	F54	Psychological Factors Affecting Other Medical Conditions
799.59	R41.9	Unspecified Neurocognitive Disorder
309.24	F43.22	Adjustment Disorder With Anxiety
309.0	F43.21	Adjustment Disorder With Depressed Mood
309.3	F43.24	Adjustment Disorder With Disturbance of Conduct

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NARCISSISTIC TRAITS

BEHAVIORAL DEFINITIONS

1. Displays a grandiose sense of self-importance and self-worth.
2. Reports fantasies about unlimited power, success, intelligence, or beauty.
3. Verbalizes a belief in being a special person who is appreciated by other special people.
4. Demonstrates a powerful need to be recognized, admired, and adored.
5. Becomes angry and resentful when wishes, wants, and needs are not met immediately by others.
6. Demonstrates a lack of empathy for others.
7. Verbalizes unreasonable expectations of others in relationships, with little concern for the other person.
8. Verbalizes envy of others or feeling others are envious of him/her.
9. Brags about achievements, exaggerated abilities, and body image.
10. Is interpersonally manipulative and exploitive.
11. Is overly demanding in interpersonal relationships having little empathy for the needs, wishes, and wants of the significant other.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and the negative effects of narcissistic traits.

2. Develop a realistic sense of self, without narcissistic grandiosity, exaggeration, or sense of entitlement.
3. Understand the relationship between narcissistic traits and addiction.
4. Understand narcissistic traits and how the sense of omnipotence places the client at high risk for relapse.
5. Develop empathy for other people, particularly victims of his/her narcissism.
6. Learn and demonstrate healthy impulse-control skills.
7. Learn how cognitive distortions create unrealistic expectations from others.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that results from narcissistic traits and addiction. (1)

2. Verbalize an identification of several narcissistic traits and describe how they contribute to addictive behavior. (2, 3)

3. Complete psychological testing or objective questionnaires for assessing narcissistic traits. (4)

THERAPEUTIC INTERVENTIONS

1. Help the client see that narcissistic traits and addictive behavior lead to a state of powerlessness and unmanageability (or assign the client to complete the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Assist the client in identifying his/her narcissistic traits, and how they can lead to addictive behavior.

3. Help the client to identify times when narcissistic traits and addictive behavior led to negative consequences.

4. Administer to the client psychological instruments designed to objectively assess narcissistic traits (e.g., Millon

Clinical Multiaxial Inventory-III); give the client feedback regarding the results of the assessment and test again if necessary to assess progress in treatment.

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

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Verbalize a commitment to honesty and humility that can form the basis for a program of recovery. (9, 10, 11)	9. Teach the client how a 12-step recovery program can assist in recovery from narcissistic traits and addiction.
	10. Teach the client that honesty is essential for real intimacy, and explain how lies lead to interpersonal frustration and loneliness.
	11. Discuss why resolution of narcissistic traits, especially the tendency toward dishonesty and feeling superior and all-powerful, is essential in maintaining abstinence.
6. List 10 lies that were told to exaggerate accomplishments and to seek acceptance and recognition. (12)	12. Assign the client to list common lies told to exaggerate accomplishments and bolster self-image; show why the self-defeating lies eventually led to the rejection from others that he/she feared.
7. List several narcissistic strategies used to manipulate others in relationships. (13)	13. Assist the client in listing ways in which he/she has used narcissistic traits to control and manipulate others; explain how narcissistic behaviors are counterproductive to interpersonal acceptance and respect.

8. Identify with the vulnerable revelations of other people by sharing similar experiences, feelings, and thoughts. (14, 15)

14. Conduct or refer the client for group therapy sessions that focus on developing empathy, by asking him/her to share with the group members his/her similar vulnerable, anxious experiences, feelings, and/or thoughts.

15. Use role-playing, modeling, and behavior rehearsal to teach the client self-disclosure of feelings of vulnerability.

9. Verbalize how the dynamics of the family of origin led to a poor self-image and a sense of rejection and failure. (16)

16. Probe the client's family of origin for experiences of criticism, emotional abandonment or rejection, and abuse or neglect that led to feelings of low self-esteem masked by narcissism.

10. Identify a pattern of inaccurate fearful thoughts triggering grandiose thoughts and replace these thoughts with accurate, but realistic, self-talk. (17, 18)

17. Probe the client's narcissistic thoughts (e.g., grandiosity, sense of entitlement, tendency to blame others, need to exaggerate achievements in search of acceptance); show the client how these thoughts are based in low self-esteem and an expectation of rejection, then replace this pattern with confident, realistic self-talk (or assign "What Are My Good Qualities?" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. Teach the client to replace cognitive messages of low self-esteem and fear of rejection with more realistic, healthy, and adaptive self-talk (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

11. Acknowledge that low self-esteem and fear of failure or

19. Confront expressions of entitlement and braggadocio,

rejection are felt internally, in spite of the external facade of braggadocio. (19, 20)

interpreting them as a cover for feelings of fear and low self-esteem.

20. Reinforce the client's social interactions that are characterized by humility, empathy, honesty, and compassion (or assign "Getting Out of Myself" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

12. List ways in which a higher power can assist in recovery from narcissistic traits and addiction. (21, 22)

21. Teach the client about the 12-step recovery program's concept of a higher power and how this can be used in recovery (e.g., see God, not self, as the higher power, trust God to help with temptations, help others in recovery, and practice regular prayer and meditation).

22. Teach the client how to turn over problems to a higher power (or assign the client to complete the Step 3 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

13. Verbalize a commitment to helping others as essential to recovery from narcissistic traits and addictive behavior. (23)

23. Teach the client that helping others will give him/her a genuine sense of self-worth, which is essential to working through a good program of recovery (or assign "Being Genuinely Unselfish" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

14. Practice honesty and realistic humility in communication with others. (24, 25)

24. Using modeling, role-playing, and behavior rehearsal, teach the client the impulse control skills of stopping, looking, listening, thinking, and planning before acting without regard for others' feelings.

25. Using modeling, role-playing, and behavior rehearsal, teach the client healthy interpersonal communication skills (e.g., honesty, ask for what you want, share how you feel, care about what the other person wants, active listening, and the use of "I messages").

15. Write a personal recovery plan that details the regular attendance at recovery groups and further treatments that are needed to recover from narcissistic traits and addictive behavior. (26)

26. Help the client to develop a personal recovery plan that will detail what he/she is going to do for further treatment in recovery such as attend recovery groups regularly, get a sponsor, or seek further treatment or therapy (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

16. Family members verbalize what each can do to assist the client in recovery. (27, 28, 29)

27. Discuss with family members the connection between narcissistic traits and addictive behavior.

28. In a family session, review what each member can do to assist the client in recovery (recommend *Disarming the Narcissist: Surviving & Thriving With the Self-Absorbed* by Behary; *Coping With Infuriating, Mean, Critical People: The Destructive Narcissistic Pattern* by Brown).

29. Provide family members with information about narcissistic traits and the steps that the client must take to recover successfully.

17. Complete a survey to assess the degree of satisfaction with treatment. (30)

30. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	_____	_____
	_____	_____
Axis II:	301.81	Narcissistic Personality Disorder
	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
301.81	F60.81	Narcissistic Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.50	F60.4	Histrionic Personality Disorder

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

NICOTINE ABUSE/DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Demonstrates a maladaptive pattern of tobacco use, manifested by increased tolerance and withdrawal.
2. Is unable to stop or cut down use of tobacco once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Exhibits physical indicators (chronic obstructive lung disease, bronchitis, lung cancer, oral cancers, etc.) that reflect the results of a pattern of heavy tobacco use.
4. Denies that nicotine dependence is a problem, despite feedback from significant others that the use of tobacco is negatively affecting him/her and others.
5. Continues tobacco use despite knowledge of experiencing persistent physical, financial, vocational, social, and/or relationship problems that are directly caused by the use of nicotine.
6. Presents with physical withdrawal symptoms (e.g., nicotine craving, anxiety, insomnia, irritability, depression) when going without nicotine for any length of time.
7. Consumes tobacco in greater amounts than intended.
8. Continues to use mood-altering chemicals after being told by a physician that using is causing health problems.
9. Nicotine dependence is concurrent with other addictive behaviors, and their practice reinforces one another.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over tobacco, and participate in a recovery-based program of abstinence.
2. Accept chemical dependence on tobacco and begin to actively participate in a recovery program.
3. Withdraw from tobacco, stabilize physically and emotionally, and then establish a supportive recovery plan.
4. Establish and maintain total abstinence from tobacco products while increasing knowledge of the addiction and the process of recovery.
5. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Cooperate with a medical assessment and an evaluation of the necessity for pharmacological intervention, taking medications as directed. (1, 2)	1. Refer the client to a physician to perform a physical exam and write treatment orders, including, if necessary, prescribing medications, monitoring the effectiveness and side effects of medication, and titrating as necessary. 2. Direct the staff to administer prescribed medications to the client and monitor for effectiveness and side effects.
2. Complete psychological testing or objective questionnaires for assessing nicotine abuse/dependence. (3)	3. Administer to the client psychological instruments designed to objectively assess nicotine abuse/dependence (e.g., Addiction Severity Index, Substance Abuse Subtle Screening Inventory-3,

Fagerstrom Test for Nicotine Dependence); give the client feedback regarding the results of the assessment.

3. Report acute withdrawal symptoms to the staff. (4)
4. Direct the staff to assess and monitor the client's condition during withdrawal.
4. Provide honest and complete information for a chemical dependence biopsychosocial history. (5)
5. Complete a thorough family and personal biopsychosocial history that has a focus on nicotine abuse and any other addictions.
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. Attend didactic sessions and read assigned material in order to increase knowledge of tobacco abuse and the process of recovery. (10, 11, 12)	10. Assign the client to attend a nicotine dependence didactic series to increase knowledge of the patterns and effects of nicotine dependence.
	11. Require the client to attend all nicotine dependence didactics; ask him/her to identify several key points attained from each didactic, and process these points with the therapist.
	12. Ask the client to read literature of nicotine dependence etiology and its negative social, emotional, and medical consequences (e.g., *American Lung Association 7 Steps to a Smoke Free Life* by Fisher and Koop; *Quitting Smoking for Dummies* by Brizer); process five key points gained from the reading.
7. Attend group therapy sessions to share thoughts and feelings associated with reasons for,	13. Assign the client to attend group therapy that focuses on nicotine dependence recovery issues.

consequences of, feelings about, and alternatives to nicotine abuse. (13, 14)

8. List the negative consequences resulting from or exacerbated by nicotine dependence. (15)

9. Verbally admit to powerlessness over nicotine. (16)

10. Verbalize recognition that nicotine was used as the primary coping mechanism to escape from stress or pain, and resulted in negative consequences. (17)

11. List the negative emotions that were caused by or exacerbated by nicotine dependence. (18)

12. Develop a list of social, emotional, and family factors that contributed to nicotine dependence. (19)

13. List 10 reasons to work on a plan for recovery from nicotine use. (20)

14. Direct group therapy that facilitates the sharing of causes for, consequences of, feelings about, and alternatives to nicotine dependence.

15. Ask the client to make a list of the ways in which nicotine dependence has negatively impacted his/her life (e.g., medically, socially, financially, productivity, etc.); process the list with the therapist or group (or assign "Assessing Readiness and Preparing to Quit" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

16. Assign the client to complete a 12-step program's Step 1 paper admitting to powerlessness over nicotine and present it in group therapy or to the therapist for feedback.

17. Explore how nicotine abuse was used to escape from stress, physical and emotional pain, and boredom; confront the negative consequences of this pattern.

18. Probe the sense of powerlessness, shame, guilt, and low self-worth that has resulted from nicotine abuse and its consequences.

19. Using the biopsychosocial history, assist the client in understanding the familial, emotional, and social factors that contributed to the development of nicotine dependence (e.g., modeling effects of older adults, peer pressure, and anxiety).

20. Assign the client to write a list of 10 reasons to be abstinent from nicotine dependence.

14. List 10 lies used to hide nicotine abuse. (21)

21. Help the client see the dishonesty that accompanies nicotine dependence; have him/her list 10 lies he/she told to hide tobacco use, and then teach him/her why honesty is essential to recovery.

15. Report success in practicing turning problems over to a higher power each day. (22, 23)

22. Teach the client about the concept of a higher power and how this can assist in recovery (e.g., God's power can assist in resisting temptation, regular prayer and meditation can reduce craving and stress).

23. Using a recovery program's Step 3 exercise, teach the client about the concept of *turning it over*, then assign turning over problems to a higher power each day; have the client record the event and discuss the results.

16. Practice healthy communication skills to reduce interpersonal stress and increase positive social interaction. (24, 25)

24. Teach the client healthy communication skills (e.g., using "I messages," reflecting, active listening, empathy, being reinforcing, sharing).

25. Refer the client for or teach him/her social interaction skills to reduce the interpersonal anxiety that triggered nicotine use (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planne*r by Jongsma).

17. Practice problem-solving skills. (26)

26. Using modeling, role-playing, and behavior rehearsal, teach the client how to solve problems in an organized fashion (i.e., write the problem, think accurately, list the options of action, evaluate alternatives, act, monitor and evaluate results); select a problem the client is

facing and apply the problem-solving process to this problem (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. List the reasons for nicotine use and the ways the same things can be attained in an adaptive manner. (27)

27. Assist the client in clarifying why he/she was using nicotine, and help him/her to identify adaptive ways to obtain the sought-after result (e.g., deep muscle relaxation, slow rhythmic breathing, imagining calm scenes, problem-solving, physical exercise, cognitive restructuring, and positive self-talk).

19. Participate in a cognitive-behavioral group treatment program for smoking cessation. (28, 29)

28. Conduct or refer the client to a smoking cessation group therapy based on a cognitive-behavioral approach (see *Smoking Cessation With Weight Gain Prevention: Therapist Guide* by Spring).

29. Assign the client readings from workbooks consistent with the treatment approach as needed to support work done in session (see *Smoking Cessation With Weight Gain Prevention: Client Workbook* by Spring).

20. Learn and implement calming skills to reduce overall stress levels, calm acute stress, and attain a feeling of relaxation and comfort. (30, 31)

30. Use calming skills (e.g., progressive deep muscle relaxation or biofeedback) to teach the client how to relax and apply relaxation when tense; assign him/her to relax twice a day for 10 to 20 minutes and to substitute relaxation for smoking.

31. Using current physical fitness levels, urge the client to exercise three times a week; increase the exercise by 10% a week until he/she is exercising at a training

heart rate for at least 20 minutes at least three times a week.

21. Implement the use of cognitive techniques to replace negative messages with alternative positive self-talk. (32, 33)

32. Use cognitive techniques to help the client identify self-talk that triggers anxiety and tension as well as provides excuses to smoke; develop with the client cognitive techniques that facilitate calming, coping, and abstinence from nicotine use (e.g., alternative self-talk, distraction).

33. Assist the client in creating a list of affirming self-statements that will build confidence in overcoming the urge to smoke until the urge passes (or assign "Use of Affirmations for Change" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

22. Learn and implement skills for identifying and coping with high-risk triggers that may precipitate relapse. (34, 35, 36)

34. Use a relapse prevention approach to help the client uncover his/her triggers for relapse into nicotine dependence.

35. Teach the client about high-risk situations (e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, testing personal control); assist the client in developing a written plan to cope with each high-risk situation (or assign "Addressing Relapse Triggers" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

36. Using modeling, role-playing, and behavior rehearsal, teach the client a coping skills set that combines various preventative (e.g., identification and

avoidance of triggers) and coping techniques (e.g., calming, cognitive challenging, behavioral self-control) to prevent exposure to triggers and/or cope with triggers that are encountered (see *Behavioral Treatment of Cigarette Smoking* by McClanahan and Antonuccio).

23. Implement a structured behavior modification program for nicotine abstinence. (37, 38, 39, 40)

37. Design, with the client, a behavior modification program that targets nicotine abuse and reinforces periods of abstinence.

38. Use techniques designed to be aversive to the experience of smoking such as smoke holding, rapid smoking, and/or noxious imagery.

39. Assign implementation of a behavior modification program that replaces the positively reinforcing effect of smoking for alternative rewards for nicotine abstinence.

40. Review, process, and redirect the behavior modification to maximize success rates.

24. Invite significant other into treatment to support smoking cessation efforts. (41).

41. Coach the client and significant other on how to support each other in the smoking cessation effort.

25. Comply with a referral to a physician for an evaluation of nicotine replacement therapy or prescription medication. (42, 43)

42. Refer to a physician for an evaluation of the safety and potential efficacy of nicotine replacement therapy (e.g., patch or gum) to be used in conjunction with a smoking cessation program.

43. Refer to a physician for an evaluation of the safety and

potential efficacy of a medication (e.g., Wellbutrin, Zyban, Chantix) for smoking cessation and relapse prevention in conjunction with a smoking cessation program.

26. Report any side effects and on the effectiveness of the nicotine replacement therapy or prescription medication to appropriate professionals. (44, 45)

27. Discontinue nicotine replacement therapy and/or prescription medication under physician supervision. (46)

28. Complete a survey to assess the degree of satisfaction with treatment. (47)

44. Educate the client about the use, side effects, and expected benefits of psychotropic medications.

45. Monitor the client's medication compliance, side effects, and effectiveness.

46. Work with a physician to help the client fade nicotine replacement therapy and/or prescription medication toward discontinuing it after a sufficient period of abstinence from tobacco use.

47. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	305.1	Nicotine Dependence
	292.0	Nicotine Withdrawal
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
305.1	F17.200	Tobacco Use Disorder, Moderate or Severe
292.0	F17.203	Tobacco Withdrawal

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

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

OBSESSIVE-COMPULSIVE DISORDER (OCD)

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

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

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

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SHORT-TERM OBJECTIVES

1. Describe the history and nature of obsessions and compulsions, as well as the role and pattern of substance use. (1, 2)

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

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the frequency, intensity, duration, and history of the client's obsessions and compulsions (consider using a structured interview such as The Anxiety Disorders Interview Schedule—Adult Version), as well as probing the pattern and role of substance use.
3. Refer the client to a general physician for a complete medical examination to rule out medical or substance-related etiology for the anxiety.
4. Assist the client in following up on the recommendations from a physical evaluation, including medications, lab work, or specialty assessments.

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

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

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

5. Administer an objective measure of OCD to further assess its depth and breadth (e.g., The Yale-Brown Obsessive-Compulsive Scale; Obsessive-Compulsive Inventory–Revised); re-administer as indicated to assess treatment progress.

6. Perform a thorough substance abuse evaluation and make the client's substance abuse a focus of treatment if warranted.

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. Cooperate with an evaluation by a physician for psychotropic medication. (11, 12)	11. Arrange for an evaluation for a prescription of psychotropic medications (e.g., serotonergic medications).
	12. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.
7. Keep a daily journal of obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken. (13)	13. Ask the client to self-monitor obsessions, compulsions, and triggers; record thoughts, feelings, and actions taken; routinely process the data to facilitate the accomplishment of therapeutic objectives (or assign "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework Planner* by Jongsma).
8. Verbalize an accurate understanding of OCD, how it	14. Convey a biopsychosocial model for the development and

develops, and how it is maintained. (14)

maintenance of OCD, highlighting the role of unwarranted fear and avoidance in its maintenance (see *Mastery of Obsessive-Compulsive Disorder—Therapist Guide* by Kozak and Foa).

9. Verbalize an understanding of the treatment rationale for OCD. (15, 16)

15. Provide a rationale for treatment to the client, discussing how treatment serves as an arena to desensitize learned fear, reality-test obsessional fears and underlying beliefs, and build confidence in managing fears without compulsions (see *Mastery of Obsessive-Compulsive Disorder—Therapist Guide* by Kozak and Foa).

16. Assign the client to read psychoeducational chapters of books or treatment manuals or consult other recommended sources for information on the rationale for exposure and ritual prevention therapy and/or cognitive restructuring for OCD (e.g., *Mastery of Obsessive-Compulsive Disorder—Client Workbook* by Foa and Kozak; *Getting Over OCD* by Abramowitz; *The OCD Workbook: Your Guide to Breaking Free from Obsessive-Compulsive Disorder* by Hyman and Pedrick).

10. Identify and replace biased, fearful self-talk and beliefs. (17, 18)

17. Explore the client's biased schema and self-talk that mediate his/her obsessional fears and compulsions; assist him/her in generating thoughts that correct for the biases; use rational disputation and behavioral experiments to test fearful versus alternative

predictions (see "Obsessive-Compulsive Disorder" by Salkovskis and Kirk).

18. Assign the client a homework exercise in which he/she identifies fearful self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments (or assign "Journal and Replace Self-Defeating Thoughts" or "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

11. Participate in imaginal or in vivo exposure to feared internal and/or external cues. (19, 20, 21, 22)

19. Assess the nature of any internal cues (thoughts, images, and impulses) and external cues (e.g., persons, objects, and situations) that precipitate the client's obsessions and compulsions.

20. Assist the client in the construction of hierarchies of feared internal and external fear cues.

21. Conduct exposure (imaginal and/or in vivo) to the internal and/or external OCD cues; begin with exposures that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see *Mastery of Obsessive-Compulsive Disorder—Therapist Guide* by Kozak and Foa; or *Understanding and Treating Obsessive-Compulsive Disorder* by Abramowitz).

22. Assign the client a homework exercise in which he/she repeats

	the exposure to the internal and/or external OCD cues, using response prevention and restructured cognitions, and records responses (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during subsequent sessions, reinforcing success, problem-solving obstacles, and providing corrective feedback toward improvement (see *Mastery of Obsessive-Compulsive Disorder—Therapist Guide* by Kozak and Foa). EBP
EBP 12. Verbalize an understanding of relapse prevention. (23, 24)	23. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it. EBP
	24. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern thinking, feeling, and behaving that is characteristic of OCD. EBP
13. Identify situations at risk for a lapse and strategies for managing these risk situations. (25, 26, 27, 28)	25. Identify high-risk situations and rehearse the management of future situations or circumstances in which lapses could occur. EBP
	26. Instruct the client to routinely use strategies learned in therapy (e.g., continued everyday exposure, cognitive restructuring, problem-solving), building them into his/her life as much as possible. EBP
	27. Develop a coping card or other reminder on which coping

strategies and other helpful information can be kept and consulted by the client as needed (e.g., steps in problem-solving, positive coping statements, other strategies that were helpful to the client during therapy).

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

14. Participate in Acceptance and Commitment Therapy (ACT) for OCD. (29, 30, 31, 32)

29. Use an ACT approach to OCD to help the client accept and openly experience obsessive thoughts, images, and impulses without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

30. Teach mindfulness meditation to help the client recognize the negative thought processes associated with OCD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing but not reacting to non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [audio CD] by Zabat-Zinn).

31. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

32. Assign the client reading consistent with the mindfulness and ACT approach to

supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).

15. Verbalize and clarify feelings connected to key life conflicts. (33, 34)

33. Encourage, support, and assist the client in identifying and expressing feelings related to key unresolved life issues.

34. Explore the resolution of identified interpersonal or other identified life conflicts; assist the client with acceptance of those that cannot be changed or use a conflict-resolution approach to address those that can.

16. Gain insight into how childhood experiences might influence current struggles with OCD and take appropriate actions. (35)

35. Use an insight-oriented approach to explore how current obsessive themes (e.g., cleanliness, symmetry, aggressive impulses) may be related to unresolved developmental conflicts (e.g., psychosexual, interpersonal); process toward the goal of insight and change.

17. Develop and implement a daily ritual that interrupts the current pattern of compulsions. (36)

36. Help the client create and implement a ritual (e.g., find a job that the client finds necessary but very unpleasant, and have him/her do this job each time he/she finds thoughts becoming obsessive); follow up with the client on the outcome of its implementation and make necessary adjustments.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.3	Obsessive-Compulsive Disorder
	300.00	Anxiety Disorder NOS
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	_____	_____
Axis II:	301.4	Obsessive-Compulsive Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.3	F42	Obsessive-Compulsive Disorder
300.00	F41.9	Unspecified Anxiety Disorder
301.4	F60.5	Obsessive-Compulsive Personality Disorder

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

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

OCCUPATIONAL PROBLEMS

BEHAVIORAL DEFINITIONS

1. Reports feelings of inadequacy, fear, and failure following severe business losses.
2. Has a history of rebellion against and/or conflicts with authority figures in the employment situation.
3. Is unemployed due to the negative effects of addictive behavior on work performance and attendance.
4. Reports that work environment is too stressful, leading to addictive behavior to escape stress.
5. Works with people who are alcohol and/or drug abusers and are supportive of addiction, increasing the risk for relapse.
6. Risks loss of job due to addictive behavior.
7. Lacks employer understanding of addiction or what is required for recovery.
8. Retirement has led to feelings of loneliness, lack of meaning in life, and addictive behavior.
9. Experiences anxiety related to perceived or actual job jeopardy due to addictive behavior.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and occupational problems.

2. Educate employers and coworkers to be supportive of recovery.
3. Fill life with new interests, so retirement can be appreciated.
4. Understand the relationship between the stress of occupational problems and addiction.
5. Make a contract with management that details the recovery plan and consequences of relapse.
6. Cooperate with a program that will lead to becoming employed again.

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SHORT-TERM OBJECTIVES

1. Identify occupational problems and how they relate to addiction. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing occupational problems. (3)

3. Identify own role in the conflict with coworkers or supervisor. (4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Take a history of the client's occupational problems; explore what employment patterns were modeled in the family of origin.
2. Teach the client how his/her occupational problems led to his/her addiction.
3. Administer to the client psychological instruments designed to objectively assess occupational problems (e.g., the *16 Personality Factors Questionnaire*); give the client feedback regarding the results of the assessment and test again, if necessary, to assess treatment progress.
4. Confront projection of responsibility for the client's behavior and feelings onto others.
5. Assist the client in identifying his/her patterns of interpersonal

conflicts that occur beyond the work setting; relate these patterns to current occupational problems.

6. Probe family-of-origin history for how the client may have learned dysfunctional relationship patterns; relate these patterns to current coworker/supervisor conflicts (or assign the "Understanding Family History" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

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).
5. Identify own behavioral changes that would help resolve conflict with coworkers or supervisors. (11, 12)	11. Assist the client in listing behavioral changes that he/she could make to resolve conflicts with coworkers and supervisors; assign implementation of these changes.
	12. Review the client's attempts to implement behavioral changes at work; reinforce success and redirect for failure.
6. Acknowledge the interaction between occupational problems and addictive behavior. (13, 14)	13. Help the client to list times when addictive behavior led to problems at work.
	14. Assign the client to list times that occupational problems led to addictive behavior (or assign "Workplace Problems and Solutions" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
7. Verbalize why current employment increases the risk for relapse. (15)	15. Help the client to see why his/her current employment is a high risk for relapse (e.g., coworker's

	addictions, job dissatisfaction, supervisor conflict, work hours too long, absence from his/her family due to travel, ethical conflicts).
8. Verbalize feelings of fear, anger, and helplessness associated with the vocational stress. (16)	16. Probe and clarify the client's emotions regarding his/her vocational situation.
9. Identify and replace distorted cognitive messages associated with perception of job stress. (17, 18)	17. Assess and make the client aware of his/her distorted, negative cognitive messages and the schema that is connected with vocational stress; assist in identifying alternative positive messages to replace distorted self-talk (or assign "A Vocational Action Plan" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	18. Confront the client's catastrophizing the situation, leading to immobilizing anxiety.
10. Implement positive self-talk that promotes harmony with others, self-acceptance, and self-confidence. (19)	19. Teach the client healthy cognitive messages that relieve anxiety and lack of confidence (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
11. Develop a written plan to resolve occupational problems and maximize chances for recovery in the workplace. (20, 21, 22)	20. Help the client develop a written plan to resolve occupational problems and maximize recovery (e.g., regular attendance at recovery groups, regular drug testing, management monitors recovery plan, honesty with management and coworkers).
	21. Meet with the client and his/her employer to educate the employer about addiction and to gain support for treatment and recovery.
	22. Help the client to learn the skills necessary to remain abstinent in

his/her current work environment (e.g., honesty with management and coworkers, regular attendance at recovery group meetings, using a sponsor, eliciting the support of management, continued treatment).

12. Implement the assertiveness skills that are necessary to be honest with coworkers about addiction and recovery. (23, 24)

23. Using modeling, role-playing, and behavior rehearsal, have the client practice telling his/her coworkers and employer the truth about his/her addictive behavior and plans for recovery.

24. Use role-playing, behavior rehearsal, and modeling to teach the client assertiveness skills (recommend the client read *Your Perfect Right* by Alberti and Emmons).

13. List the skills or changes that will help in coping with the stress of the current occupation. (25)

25. Help the client to develop skills to reduce job stress and improve employment satisfaction (e.g., time management; relaxation; exercise; assertiveness; reducing responsibilities, work hours, and/or travel time; realistic expectations of work performance).

14. List five ways in which working a program of recovery will improve occupational problems. (22, 26)

22. Help the client to learn the skills necessary to remain abstinent in his/her current work environment (e.g., honesty with management and coworkers, regular attendance at recovery group meetings, using a sponsor, eliciting the support of management, continued treatment).

26. Teach the client how working a 12-step recovery program will improve occupational problems.

15. Make written plans to change employment to a job that will be supportive to recovery. (27)

16. Turn the stress of occupational problems and the urge for addictive behavior over to a higher power at least once a day. (28, 29)

17. Honestly acknowledge the negative impact that addiction has had on work performance. (30)

18. Enter a Supported Employment Program. (31)

19. Discuss the grief over retirement, and make written plans to replace addictive behavior with specific constructive activities. (32, 33)

27. Help the client to accept the need to change jobs to employment that will be more supportive to recovery (or assign "Interest and Skill Self-Assessment" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

28. Teach the client about the 12-step recovery program's concept of a higher power and how this can assist in recovery.

29. Teach the client how to turn problems over to a higher power; assign him/her to practice turning problems over to a higher power at least once a day (or assign the client to complete the Step 3 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

30. Help the client to be honest with himself/herself, coworkers, and management about the negative impact of addictive behavior on job performance; list the negative consequences of addictive behavior on employment.

31. Refer the client to an evidence-based Supported Employment Program; consult as needed with its staff and follow the client's progress (see *Supported Employment* by Swanson).

32. Explore and resolve the client's feelings associated with retirement.

33. Assist the client in making plans to engage in constructive activities (e.g., volunteering, hobbies, exercise, social contacts, special-interest groups, 12-step recovery program meetings, continuing education, and religious involvement).

20. Family members verbalize what each can do to assist the client in recovery. (34, 35)

21. Complete a survey to assess the degree of satisfaction with treatment. (36)

34. Discuss with family members the connection between occupational problems and addictive behavior.

35. In a family session, review what each member can do to assist the client in recovery.

36. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	V62.81	Relational Problem NOS
	V62.2	Occupational Problem
	V62.89	Phase of Life Problem
	300.02	Generalized Anxiety Disorder
	311	Depressive Disorder NOS
	309.0	Adjustment Disorder With Depressed Mood
	309.24	Adjustment Disorder With Anxiety
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
V62.2	Z56.9	Other Problem Related to Employment
V62.89	Z60.0	Phase of Life Problem

300.02	F41.1	Generalized Anxiety Disorder
311	F32.9	Unspecified Depressive Disorder
311	F32.8	Other Specified Depressive Disorder
309.0	F43.21	Adjustment Disorder With Depressed Mood
309.24	F43.22	Adjustment Disorder With Anxiety
301.7	F60.2	Antisocial Personality Disorder
301.0	F60.0	Paranoid Personality Disorder

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

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

OPPOSITIONAL DEFIANT BEHAVIOR

BEHAVIORAL DEFINITIONS

1. Has a history of explosive, aggressive outbursts.
2. Often argues with authority figures over requests or rules.
3. Deliberately annoys people as a means of gaining control.
4. Blames others rather than accept responsibility for own problems.
5. Displays angry overreaction to perceived disapproval, rejection, or criticism.
6. Passively withholds feelings and then explodes in a violent rage.
7. Abuses substances to cope with feelings of anger and alienation.
8. Has a persistent pattern of challenging or disrespecting authority figures.
9. Demonstrates body language of tense muscles (e.g., clenched fists or jaw, glaring looks, or refusal to make eye contact).
10. Verbalizes a view of aggression as a means to achieve needed power and control.
11. Uses verbally abusive language.
12. Expresses deep resentment toward authority figures.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and oppositional defiant behavior.
2. Decrease the frequency of occurrence of angry thoughts, feelings, and behaviors.

3. Follow rules established by authority figures, without opposition or complaint.
4. Stop blaming others for problems and begin to accept responsibility for own feelings, thoughts, and behaviors.
5. Learn and implement stress management skills to reduce the level of stress and the irritability that accompanies it.
6. Parents learn and implement good child behavioral management skills.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Acknowledge feelings of anger and identify trigger situations. (1, 2, 3)	1. Explore the client's angry feelings and assist him/her in identifying sources for his/her anger. 2. Assign the client to keep a daily anger log, writing down each situation that produced angry feelings and the thoughts associated with the situation; then rate the level of anger on a scale from 1 to 100; process the anger log, and assist in uncovering the dysfunctional thoughts that trigger anger. 3. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
2. Complete psychological testing or objective questionnaires for assessing defiance of authority. (4)	4. Administer to the client psychological instruments designed to objectively assess traits of oppositional defiance

(e.g., Adolescent Psychopathology Scale—Short Form, Millon Adolescent Clinical Inventory); give the client feedback regarding the results of the assessment and test again, if necessary, to assess treatment progress.

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

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

	8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Verbalize an understanding of how angry thoughts and feelings can lead to an increased risk of addiction. (9, 10, 11)	9. Educate the client about his/her tendency to use addictive behavior as a means of relieving uncomfortable feelings; develop a list of several instances of this occurrence.
	10. Teach the client about the high-risk situations of strong negative emotions, social pressure, interpersonal conflict, strong positive emotions, and testing personal control; discuss how anger, as a strong negative emotion, places him/her at high risk for addictive behavior.
	11. Assist the client in identifying reasons why anger increases the risk of relapse.
5. Cooperate with a physician evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (12)	12. Assess the client for the need for psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.

6. Agree to learn alternative ways to think about and manage anger and misbehavior. (13, 14)

13. Assist the client in reconceptualizing anger as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out) that can be managed (*Defiant Teens: A Clinician's Manual for Assessment and Family Intervention* by Barkley, Edwards, and Robin).

14. Assist the client in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved physical health, etc.); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior.

7. Learn and implement calming strategies as part of a new way to manage reactions to frustration and defiance. (15)

15. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings and the urge to defy when they occur (or assign "Self-Soothing: Calm Down, Slow Down" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

8. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that facilitates more constructive reactions. (16)

16. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should*, *must*, or *have* to statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and

	facilitates a more flexible and temperate response to frustration (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT
EBT 9. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out. (17)	17. Assign the client to implement a thought-stopping technique on a daily basis between sessions (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); review implementation; reinforce success, providing corrective feedback toward improvement. EBT
EBT 10. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (18)	18. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction (or assign "Assertive Communication of Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT
EBT 11. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (19)	19. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts. EBT
EBT 12. Practice using new calming, communication, conflict resolution, and thinking skills in session with the therapist and during homework exercises. (20, 21)	20. Assist the client in constructing and consolidating a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs. EBT

21. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or feedback of videotaped practice in increasing challenging situations to help the client consolidate the use of his/her new anger and behavior management skills.

13. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (22, 23)

22. Assign the client homework exercises to help him/her practice newly learned calming (e.g., use "Safe and Peaceful Place Meditation" in the *Addiction Treatment Homework Planner* by Finley and Lenz), assertion, conflict resolution, or cognitive restructuring skills as needed; review and process toward the goal of consolidation.

23. Assist the client in reframing complaints into requests for positive change (or assign the exercise "Filing a Complaint" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis or "Learning to Ask Instead of Demand" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

14. Parents learn and implement Parent Management Training skills to recognize and manage the problem behavior of the client. (24, 25, 26, 27, 28)

24. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., see *Parenting the Strong-Willed Child* by Forehand and Long;

Living With Children by Patterson; *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

25. Teach the parents how to specifically define and identify problem behaviors, identify their own reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.
26. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior; prompting of positive behavior in the environment; use of positive reinforcement to encourage behavior (e.g., praise); use of calm, clear direct instruction, time out, and other loss-of-privilege practices for problem behavior.
27. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.
28. Ask the parents to read parent training manuals to supplement in-session parent training (e.g., *Parents and Adolescents Living*

Together: The Basics by Patterson and Forgatch; *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

15. Decrease the frequency and intensity of hostile, negativistic, and defiant interactions with parents/adults. (29)

29. Track the frequency and intensity of negative, hostile feelings and defiant behaviors and problem-solve solutions; implement a plan toward decreasing frequency and intensity.

16. Increase the frequency of civil, respectful interactions with parents/adults. (30, 31, 32)

30. Establish with the client the basics of treating others respectfully. Teach the principle of reciprocity, asking him/her to agree to treat everyone in a respectful manner for a one-week period to see if others will reciprocate by treating him/her with more respect; track results, problem-solve, and revisit toward increasing respectful interactions.

31. Use a therapeutic game (e.g., The Talking, Feeling, and Doing Game by Gardner, available from Creative Therapeutics, or The Ungame by Zakich, available from The Ungame Company) to expand the client's ability to express feelings respectfully.

32. Videotape a family session, using appropriate portions to show the family interaction patterns that are destructive; teach family members, using role-playing, role reversal, and modeling, to implement more respectful patterns.

17. Identify and verbalize the pain and hurt of past and current life that fuels oppositional defiant behavior. (33, 34, 35)

33. Assign the client to list experiences of life that have hurt and have led to oppositional defiant behavior.

	34. Probe the patterns of violence, anger, and suspicion in the family of origin; help the client to see how these problems lead to a tendency to see people and situations as dangerous and threatening.
	35. Probe the family dynamics that led to the oppositional defiant behavior.
18. Verbalize an understanding of how anger covers feelings of hurt, guilt, or hopelessness. (36)	36. Teach the client how anger blocks the awareness of pain, discharges uncomfortable feelings, erases guilt, and places the blame for problems on someone else.
19. Verbalize an understanding of the need for and process of forgiving others, to reduce oppositional defiant behavior. (37)	37. Assist the client in identifying who he/she needs to forgive, and educate him/her as to the long-term process involved in forgiveness versus a magical single event; recommend reading material on forgiveness (e.g., *Forgive and Forget* by Smedes).
20. Recognize the role of a higher power in judging others. (38)	38. Teach the client how to turn perpetrators of pain over to his/her higher power for judgment.
21. Attend and participate in Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings. (39)	39. Encourage the client to actively attend AA/NA meetings and get a sponsor.
22. Develop an aftercare program that details what to do when feeling angry or frustrated. (40)	40. Help the client to develop a list of what adaptive action he/she is going to take when he/she feels angry in recovery (e.g., calling a sponsor, being assertive rather than aggressive, taking a time-out, praying to a higher power) to avoid relapse (or assign "Analyzing Acting-Out Behavior" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

23. Complete a survey to assess the degree of satisfaction with treatment. (41)

41. Administer a survey to assess the client's degree of satisfaction with treatment.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.81	Conduct Disorder, Childhood-Onset Type
	313.81	Oppositional Defiant Disorder
	312.8	Conduct Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.34	Intermittent Explosive Disorder
	312.30	Impulse-Control Disorder NOS
	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
	V71.02	Child or Adolescent Antisocial Behavior
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	V71.09	No Diagnosis
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.82	F91.2	Conduct Disorder, Adolescent-Onset Type
313.81	F91.3	Oppositional Defiant Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
312.34	F63.81	Intermittent Explosive Disorder

312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
309.4	F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
V71.02	Z72.810	Child or Adolescent Antisocial Behavior
301.7	F60.2	Antisocial Personality Disorder

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

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

PARENT–CHILD RELATIONAL PROBLEM

BEHAVIORAL DEFINITIONS

1. Expresses parent–child relationship stress that provides an excuse for addiction and addictive behavior, which exacerbates relationship conflicts.
2. Lack of communication between parent and child.
3. Refuses to obey parents' rules or accept their limits.
4. Exhibits poor communication skills between parent and child.
5. Demonstrates a pattern of addiction and dishonesty, leading to parent–child anger and resentments.
6. Frequent arguing and a feeling of emotional distance between parent and child.
7. Has a history of substance abuse, leading to social isolation and withdrawal.
8. Displays a pattern of verbal or physical abuse by the parent toward the child.
9. Becomes involved in a peer group to the exclusion of parents and family members.
10. Lacks ability to establish and maintain meaningful, intimate family relationships.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and parent–child conflicts.

2. Terminate addictive behavior and resolve parent–child relationship conflicts.
3. Understand the relationship between addictive behavior and parent–child conflicts.
4. Learn and demonstrate healthy communication skills.
5. Decrease parent–child conflict and increase mutually supportive interaction.

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SHORT-TERM OBJECTIVES

1. Describe the nature and history of the parent–child conflicts. (1)

2. Verbalize the powerlessness and unmanageability that result from parent–child conflicts and addiction. (2)

3. Complete psychological testing or objective questionnaires for assessing parent–child conflict. (3)

THERAPEUTIC INTERVENTIONS

1. Explore in family and individual sessions the nature and history of the client's parent–child conflicts; compare these to conflicts the parent may have had with his/her parents, possibly assigning "Understanding Family History" and/or "Identifying Conflict Themes" in the *Addiction Treatment Homework Planner* by Finley and Lenz.

2. Using a 12-step recovery program's Step 1 exercise, help the client to see how parent–child relational conflicts and addiction led to powerlessness and unmanageability.

3. Administer to the client psychological instruments designed to objectively assess parent–child relational conflict (e.g., the Parenting Stress Index, the Parent–Child Relationship

	Inventory); give the client feedback regarding the results of the assessment and test again, if necessary, to assess treatment progress.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)	4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change). 5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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). 6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior. 7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g.,

	the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. List times when addictive behavior led to parent–child relational conflicts. (8, 9)	8. Help the client to see how addiction has caused parent–child conflicts, and how conflicts have precipitated addictive behavior. 9. Ask the client to list instances when addictive behavior led to parent–child relationship conflicts.
6. List occasions when parent–child conflicts triggered addictive behavior. (10)	10. Ask the client to list occasions when parent–child conflicts triggered addictive behavior.
7. Verbalize an acceptance of responsibility for own role in parent–child relationship problems, and in choosing addictive behavior as a means of coping with relationship conflicts. (11, 12)	11. Help the client to accept the responsibility for his/her role in relationship problems and for choosing addiction as a reaction to the conflicts. 12. Confront the client's denial of responsibility for the parent–child conflict and the client's projection of all responsibility onto others (or assign "Am I Teaching My Child Addictive Patterns?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
8. Acknowledge that the child has been the victim of abuse. (13, 14, 15)	13. Assess the nature and severity of any abusive behaviors by the client toward the child.

14. Facilitate the immediate protection of the child from any further abuse (e.g., notifying legal authorities of the abuse, temporary placement of the child with other family or a friend, removal of the abusive parent from the home).
15. Refer the abusive parent to a domestic violence treatment program.

9. Identify five positive and five negative aspects of the current parent–child relationship. (16)

16. Ask the client to list five positive and five negative aspects of the parent–child relationship.

10. Each family member lists the changes that he/she believes each person must make to restore the relationship. (17, 18, 19, 20)

17. Assist the client and other family members in identifying the causes for past and present conflicts between them.
18. Assign the client the task of listing the behavioral changes that he/she needs to make and the changes that he/she believes each family member needs to make to restore the relationship.
19. Assign each and every family member the task of listing the behavioral changes that he/she needs to make and the changes that he/she believes the other family members need to make to restore the relationship.
20. In a family session, obtain a written commitment from each member as to what behaviors each will attempt to change (or assign "What Do I Want for My Children?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

11. Initiate activities that verbally and nonverbally promote intimacy. (21, 22)

21. In a family session, facilitate a discussion of parent–child problems and make plans to

	improve intimacy, nurturing, and communication.
	22. Using modeling, role-playing, and behavior rehearsal, teach the family members how to show verbal and nonverbal affection toward each other (e.g., going for a walk together, sharing feelings, doing fun things together, giving hugs, giving each other compliments and praise).
12. Learn and demonstrate healthy communication skills. (23, 24, 25)	23. Using modeling, role-playing, and behavior rehearsal, teach the client healthy communication skills such as active listening, reflecting, sharing feelings, or using "I messages" (consider assigning "Communication Skills" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	24. Facilitate a family session with the focus on teaching and improving communication skills.
	25. Assign the client to develop a written plan as to the time, place, and amount of time that will be devoted to private, one-to-one communication with each family member each day.
EB 13. Verbalize an understanding of key differences between boys and girls at different levels of development and adjust expectations and parenting practices accordingly. (26)	26. Educate the parents on key developmental differences between boys and girls, such as rate of development, perspectives, impulse control, temperament, and how these influence the parenting process. EB
EB 14. Verbalize an increased awareness and understanding of the unique issues and trials of parenting adolescents. (27, 28, 29)	27. Educate the parents about the various biopsychosocial influences on adolescent behavior including biological changes, peer influences, self-concept, identity, and parenting styles. EB

28. Teach the parents the concept that adolescence is a time in which the parents need to "ride the adolescent rapids" (see *Positive Parenting for Teenagers: Empowering Your Teen and Yourself Through Kind and Firm Parenting* by Nelson and Lott) until both survive.
29. Assist the parents in coping with the issues and reducing their fears regarding negative peer groups, negative peer influences, and losing their influence to these groups.

15. Parents verbalize an understanding of the impact of their reaction on their child's behavior. (30)

30. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., see *Parenting the Strong-willed Child* by Forehand and Long; *Living With Children* by Patterson; *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

16. Learn and implement parenting practices that have demonstrated effectiveness. (31, 32, 33)

31. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior; prompting of positive behavior in the environment; use of positive reinforcement to encourage behavior (e.g., praise); use of clear direct instruction, time-out and other loss-of-

privilege practices for problem behavior, negotiation, and renegotiation—usually with older children and adolescents (see *Defiant Teens: A Clinician's Manual for Assessment and Family Intervention* by Barkley, Edwards, and Robin; *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

32. Assign the parents home exercises in which they implement parenting skills and record results of implementation (or assign "Using Reinforcement Principles in Parenting" in the *Adult Psychotherapy Homework Planner* by Jongsma); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

33. Ask the parents to read parent-training manuals consistent with the therapy (e.g., *Parents and Adolescents Living Together: The Basics* by Patterson and Forgatch; *Parents and Adolescents Living Together: Family Problem Solving* by Forgatch and Patterson; *Your Defiant Teen* by Barkley and Robin).

17. Verbalize a sense of increased skill, effectiveness, and confidence in parenting. (34)

34. Support, empower, monitor, and encourage the parents in implementing new strategies for parenting their child; reinforce successes; problem-solve obstacles toward consolidating a coordinated, consistent, and effective parenting style.

18. Older children and adolescents learn and implement skills for managing self and interactions with others. (35, 36)

35. Use a Cognitive-Behavioral Therapy approach with older children and adolescents using several techniques such as

instruction, modeling, role-playing, feedback, and practice to teach the child how to manage his/her emotional reactions, manage interpersonal interactions, and problem-solving conflicts (see *Problem-Solving Skills Training and Parent Management Training for Conduct Disorder* by Kazdin).

36. Use structured tasks involving games, stories, and other activities in session to develop personal and interpersonal skills, then carry them into real-life situations through homework exercises; review; reinforce successes; problem-solve obstacles toward integration into the child's life.

19. Develop skills to talk openly and effectively with the children. (37, 38)

37. Use instruction, modeling, and role-play to teach the parents how to communicate effectively with their child including using open-ended questions, active listening, and respectful assertive communication that encourage openness, sharing, and ongoing dialogue.

38. Ask the parents to read material on parent–child communication (e.g., *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber and Mazlish; *Parent Effectiveness Training* by Gordon); help them implement the new communication style in daily dialogue with their children and to see the positive responses each child had to it.

20. Make written plans to increase pleasurable activities spent by the parent and child. (39, 40)

39. Help the family to make a list of the pleasurable activities that they would like to do together;

help them to make plans to become involved in at least one activity each week (possibly assigning "Creating Positive Family Rituals" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

40. Assign the client to write a letter to each family member sharing how he/she feels and suggesting pleasurable activities that they could engage in together during recovery.

21. Develop a personal recovery plan that includes regular attendance at recovery groups, getting a sponsor, and any other therapy that is necessary to recover from parent–child relational conflicts and addiction. (41, 42)

41. Help the client to develop a written personal recovery plan that includes attending recovery group meetings regularly, getting a sponsor, and any other therapy that is necessary to recover from parent–child relational problems and addiction (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

42. Teach the client and the family about 12-step recovery groups (e.g., Al-Anon, Narcanon, Adult Children of Alcoholics, Alateen).

22. Complete a survey to assess the degree of satisfaction with treatment. (43)

43. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	313.81	Oppositional Defiant Disorder
	V61.20	Parent–Child Relational Problem
	V62.81	Relational Problem NOS
	V61.21	Physical Abuse of a Child
	V61.21	Sexual Abuse of a Child
	V61.21	Neglect of a Child
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Axis II:	301.7	Antisocial Personality Disorder
	301.20	Schizoid Personality Disorder
	301.81	Narcissistic Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
313.81	F91.3	Oppositional Defiant Disorder
V61.20	Z62.820	Parent–Child Relational Problem
V61.22	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Abuse
V61.22	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Sexual Abuse
V61.21	Z69.011	Encounter for Mental Health Services for Perpetrator of Parental Child Neglect
301.7	F60.2	Antisocial Personality Disorder
301.20	F60.1	Schizoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

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

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

PARTNER RELATIONAL CONFLICTS

BEHAVIORAL DEFINITIONS

1. Frequent or continual arguing with the partner.
2. Expresses relationship stress as an excuse for addiction, which, in turn, exacerbates the relationship conflicts.
3. Lacks communication with spouse or significant other.
4. Separated from partner due to addictive behavior.
5. Reports an impending or recent divorce.
6. Has a pattern of superficial or nonexistent communication, frequent arguing, and infrequent sexual enjoyment, and a feeling of emotional distance from partner.
7. Presents with a pattern of substance use leading to social isolation and withdrawal.
8. Reports a pattern of verbal and/or physical abuse present in the relationship.
9. Engages in multiple superficial relationships, often with sexual intercourse, but without commitment or meaningful intimacy.
10. Has not established and maintained meaningful, intimate interpersonal relationships.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and partner relational conflicts.

2. Terminate addiction and resolve the relationship conflicts that increase the risk of relapse.
3. Understand the relationship between addiction and partner relational conflicts.
4. Accept termination of the relationship, and make plans to move forward in life.
5. Develop the skills necessary to maintain open, effective communication, sexual intimacy, and enjoyable time with a partner.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that result from partner relational conflicts and addiction. (1)

2. Client and partner give their perspective on the nature of and causes for the relational conflicts. (2, 3)

3. Complete psychological testing or objective questionnaires for assessing partner relational conflicts. (4)

THERAPEUTIC INTERVENTIONS

1. Using a 12-step recovery program's Step 1 exercise, help the client to see how partner relational conflicts and addiction lead to powerlessness and unmanageability.

2. Explore the client's perspective on the nature of and causes of conflicts with his/her partner.

3. In an individual or conjoint session, explore the client's partner's perspective on the nature of and causes of the conflicts between them (or assign "Identifying Conflict Themes" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

4. Administer a measure of overall marital adjustment (e.g., Dyadic Adjustment Scale), communication (e.g., Communication

	Patterns Questionnaire-Short Form), and/or satisfaction (e.g., Marital Satisfaction Inventory—Revised) to supplement interview as needed; re-administer as indicated to assess treatment progress.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)	5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change). 6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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). 7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior. 8. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. List instances when addiction has led to partner relational conflicts and relationship conflicts have led to addictive behavior. (9, 10, 11)	9. Help the client see how addiction has caused relationship conflicts, and how relationship conflicts have precipitated addiction. 10. Ask the client to list instances when addiction has led to relationship conflict. 11. Ask the client to list occasions when relationship conflicts have led to addiction.
6. Verbalize an acceptance of the responsibility for own role in relationship problems and in choosing addiction as a means of coping with relationship conflicts. (12)	12. Help the client to accept responsibility for his/her role in the relationship problems, and for choosing addiction as a means of coping with the conflicts and the emotions resulting from those conflicts.
7. Identify the positive aspects of the relationship. (13)	13. Assist the couple in identifying the positive aspects of their relationship that drew them together initially and have been rewarding since they formed a union.
8. Identify current problems in the relationship including what has been done to try to resolve issues. (14, 15)	14. Assess current, ongoing problem behaviors in the relationship, including possible abuse/neglect, substance use, and those involving communication, conflict resolution, or problem-solving difficulties.

15. Assign the couple a between-sessions task recording in journals the positive and negative things about the significant other and the relationship (or assign "Positive and Negative Contributions to the Relationship: Mine and Yours" in the *Adult Psychotherapy Homework Planner* by Jongsma); ask the couple not to show their journal material to each other until the next session, when the material will be processed.

9. Make a commitment to change specific behaviors that have been identified by self or the partner. (16)

16. Process the list of positive and problematic features of each partner and the relationship; ask the couple to agree to work on changes he/she needs to make to improve the relationship, generating a list of targeted changes (or assign "How Can We Meet Each Other's Needs and Desires?" in the *Adult Psychotherapy Homework Planner* by Jongsma).

10. Each partner negotiates and signs a contract to agree to increase positive behaviors that each partner desires. (17)

17. Develop a contract identifying negotiated behavioral changes that each partner desires within the relationship; ask the couple to sign the contract.

11. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the relationship. (18, 19, 20)

18. Assist the couple in identifying conflicts that can be addressed using communication, conflict resolution, and/or problem-solving skills (see *Behavioral Marital Therapy* by Holzworth-Munroe and Jacobson).

19. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach communication skills including

assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

20. Assign the couple a homework exercise to use and record newly learned communication skills (or assign "Communication Skills" in the *Addiction Treatment Homework Planner* by Finley and Lenz); process results in session, providing corrective feedback toward improvement.

12. Identify any patterns of destructive and/or abusive behavior in the relationship. (21, 22)

21. Assess current patterns of destructive and/or abusive behavior for each partner, including those that existed in each family of origin.

22. Ask each partner to make a list of escalating behaviors that occur prior to abusive behavior.

13. Implement a time-out signal that either partner may give to stop interaction that may escalate into abuse. (23, 24, 25)

23. Assist the partners in identifying a clear verbal or behavioral signal to be used by either partner to terminate interaction immediately if either fears impending abuse.

24. Solicit a firm agreement from both partners that the time-out signal will be responded to favorably without debate.

25. Assign implementation and recording of the use of the time-out signal and other conflict resolution skills in daily interaction (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma).

14. Discuss the sexual problems that exist in the relationship and demonstrate the ability to show intimacy, verbally and nonverbally. (26, 27)

15. Participate in an evaluation to identify or rule out sexual dysfunction. (28, 29)

16. Commit to the establishment of healthy, mutually satisfying sexual attitudes and behavior that is not a reflection of destructive earlier experiences. (30, 31)

17. Verbalize acceptance of the need for continued therapy to improve the relationship and to maintain gains. (32)

18. Increase the quality and frequency of healthy communication with the partner. (33, 34)

26. In a conjoint session, facilitate a discussion of the sexual problems, and list those things each partner can do to improve intimacy and communication.

27. Using modeling, role-playing, and behavior rehearsal, teach the partners how to show verbal and nonverbal affection to each other (e.g., going for a walk together, talking intimately, holding hands, hugging, dancing, giving each other compliments and praise).

28. Gather from each partner a thorough sexual history to determine areas of strength and to identify areas of dysfunction.

29. Refer the client to a specialist for a diagnostic evaluation of sexual dysfunction (e.g., rule out organic and psychogenic factors), with recommendation for appropriate treatment (e.g., medication, sex therapy, surgery).

30. In a conjoint session identify sexual behavior, patterns, activities, and beliefs of each partner and the extended family.

31. Assist each partner in committing to attempt to develop healthy, mutually satisfying sexual beliefs, attitudes, and behaviors that are independent of previous childhood, personal, or family training or experience.

32. Help the couple to see the importance of continued therapy to improve the relationship and maintain gains.

33. Assign the client to develop a written plan as to the time, place, and amount of time that will be

devoted to private, one-to-one communication with their partner each day.

34. Facilitate a conjoint session with the focus on improving communication skills.

19. Increase the frequency of pleasurable activities with the partner. (35)

35. Help the couple to make a list of the pleasurable activities that they would like to do together; solicit a promise from them to become involved in one activity together a week.

20. Grieve the loss of the relationship and make plans to move forward in life. (36, 37)

36. Encourage the client to share the grief of losing the significant other or spouse, and help him/her make a written plan to increase social interaction and improve old relationships.

37. Encourage and support the client's efforts to build new social relationships.

21. Develop a personal recovery plan to recover from partner relational conflicts and addiction. (38)

38. Help the client develop a written personal recovery plan that includes regular attendance at recovery group meetings, getting a sponsor, and any other therapy necessary to recover from partner relational problems and addiction.

22. Complete a survey to assess the degree of satisfaction with treatment. (39)

39. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.81	Conduct Disorder, Childhood-Onset Type
	309.0	Adjustment Disorder With Depressed Mood
	309.24	Adjustment Disorder With Anxiety
	300.4	Dysthymic Disorder
	300.0	Anxiety Disorder NOS
	311	Depressive Disorder NOS
	309.81	Posttraumatic Stress Disorder
	V61.1	Partner Relational Problem
	V62.81	Relational Problem NOS
	V61.1	Physical Abuse of an Adult
	V61.1	Sexual Abuse of an Adult
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	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.20	Schizoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.32	F91.2	Conduct Disorder, Adolescent-Onset Type
309.0	F43.21	Adjustment Disorder With Depressed Mood
309.24	F43.22	Adjustment Disorder With Anxiety
300.4	F34.1	Persistent Depressive Disorder
300.00	F41.9	Unspecified Anxiety Disorder
311	F32.9	Unspecified Depressive Disorder
309.81	F43.10	Posttraumatic Stress Disorder
V61.10	Z63.0	Relationship Distress With Spouse or Intimate Partner
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
995.81	T74.11XA	Spouse or Partner Violence, Physical, Confirmed, Initial Encounter
995.81	T74.11XD	Spouse or Partner Violence, Physical, Confirmed, Subsequent Encounter

V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
301.7	F60.2	Antisocial Personality Disorder
301.20	F60.1	Schizoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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

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

PEER GROUP NEGATIVITY

BEHAVIORAL DEFINITIONS

1. Associates with friends and relatives who are chemically dependent and who encourage joining them in addictive behavior.
2. Has peers who are involved in the sale of illegal substances and who encourage joining them in criminal behavior.
3. Reports that peer group is not supportive of recovery from addiction.
4. Is involved in a gang that is supportive of criminal activity and addiction.
5. States peers do not understand addiction or the need for recovery.
6. Reports that peers laugh and joke about recovery, and continue to abuse substances.
7. Peers engage in and encourage gambling and/or substance abuse.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and the negative influences of peers.
2. Understand that continuing to associate with the current peer group increases the risk for relapse.
3. Learn the skills necessary to develop a new peer group that is drug free and supportive of working a program of recovery.
4. Attend recovery group meetings regularly, and help others who are addicted.
5. Educate family members about addiction and the need for recovery.

6. Encourage family members who are addicted to seek treatment.

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SHORT-TERM OBJECTIVES

1. Verbalize the powerlessness and unmanageability that result from peer group negativity and addictive behavior. (1)

2. Complete psychological testing or objective questionnaires for assessing the client's identification with the values of a negative peer group. (2)

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Help the client to see the powerlessness and unmanageability that result from peer group negativity and addictive behavior (or assign the client to complete the Step 1 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

2. Administer to the client psychological instruments designed to objectively assess the client's identification with the values of a negative peer group (e.g., Family Environment Scale); give the client feedback regarding the results of the assessment and test again if necessary to assess treatment progress.

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

	issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
	4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
	5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
	6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Identify several times when peer group negativity led to addictive behavior. (7, 8)	7. Help the client to see the relationship between his/her peer group and addictive behavior, particularly how often the peer

group encouraged the addictive behavior.

8. Assign the client to list instances when peers encouraged addictive behavior (or assign "What Do I Need and How Do I Get It?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

5. List times when peer group negativity led to criminal activity. (9)

9. Assign the client to list times when the peer group led him/her into criminal activity.

6. Verbalize an acceptance of the need for breaking ties with the current peer group. (10, 11, 12, 13)

10. Reinforce the client's verbalized intent to break ties with the current peer group; empathize with the difficulty in leaving friends behind and making new friends who will reinforce the changes he/she is making toward sobriety (or assign "Creating Recovery Peer Support" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

11. Help the client to grieve the loss of the old peer group and to make plans to develop new friends in recovery.

12. Help the client to understand the reasons why continuing to associate with the current peer group increases his/her risk for relapse.

13. Assist the client in listing the negative consequences associated with continuing ties to the current peer group.

7. Verbalize how peer group negativity and addictive behavior meet the 12-step recovery program's concept of *insanity*. (14)

14. Help the client see how peer group negativity and addiction meet the 12-step program's concept of *insanity* (or assign the Step 2 exercise in *The Alcoholism*

& Drug Abuse Patient Workbook by Perkinson).

8. List ways in which a higher power can assist in recovery from peer group negativity and addiction. (15, 16, 17)

15. Teach the client about the 12-step recovery program's concept of a higher power and how this power can restore him/her to sanity (e.g., asking a higher power for help in recovery, becoming involved in religious activities, practicing 12-step prayers).

16. Assist the client in identifying the ways that a higher power can assist him/her (e.g., by sending power to resist temptation, by imparting spiritual direction, by giving a feeling of acceptance).

17. Teach the client about turning problems over to a higher power each day; assign him/her to use this step at least once a day, and keep a record of using Step 3 (or assign the client to complete the Step 3 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

9. Verbalize why obeying the law is essential for working a program of recovery. (18)

18. Teach the client about the 12-step recovery program's concept of rigorous honesty, and why obeying the law is essential in working a program of recovery.

10. Attend recovery group meetings regularly, and stay for coffee and conversation after each meeting. (19, 20)

19. Assign the client to make a written plan about how he/she plans to increase social contact with a new peer group that is positive toward recovery.

20. Encourage the client to stay for coffee and conversation after each 12-step recovery program meeting to increase social skills and make new, positive friends.

11. Write an autobiography detailing the exact nature of the wrongs committed, and how these relate to the negative peer group and to addiction. (21)	21. Using a 12-step recovery program's Step 4 inventory, assign the client to write an autobiography detailing the exact nature of his/her wrongs, and how these relate to the negative peer group and to addictive behavior.
12. Refuse to engage in addictive behavior in high-risk situations. (22, 23)	22. Using modeling, role-playing, and behavior rehearsal, teach the client how to refuse to engage in addictive behavior; practice refusal in high-risk situations for relapse (e.g., negative emotions, social pressure, interpersonal conflict, positive emotions, and testing personal control).
	23. Review the client's implementation of refusal skills in high-risk situations; reinforce success, and redirect for failure (recommend *Coping With Peer Pressure* by Kaplan).
13 Meet with a temporary sponsor and make plans to attend recovery group meetings. (24)	24. Encourage and facilitate the client meeting his/her 12-step recovery program temporary sponsor, and discuss plans for recovery (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
14. Make a list of peers who are positive and peers who are negative toward recovery efforts. (25, 26)	25. Help the client to make a list of all peers who are positive or negative toward recovery (or assign the client to complete the "Building My Support Network" exercise in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	26. Assist the client in planning how to avoid or otherwise cope with peers who are unsupportive or critical of his/her recovery efforts.

15. Family members indicate who in the client's peer group needs to be avoided in recovery. (27)
16. Family members verbalize what each can do to assist the client in recovery. (28, 29)
17. Complete a survey to assess the degree of satisfaction with treatment. (30)

27. In a family session, have the family members indicate which peers need to be avoided in recovery and why.
28. Discuss with family members the connection between peer group negativity and addictive behavior; list the steps that the client must take to recover successfully.
29. In a family session, review what each member can do to assist the client in recovery.
30. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	312.8	Conduct Disorder
	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
	309.3	Adjustment Disorder With Disturbance of Conduct
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
312.8	F91.x	Conduct Disorder
309.4	F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
309.3	F43.24	Adjustment Disorder With Disturbance of Conduct
301.7	F60.2	Antisocial Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.6	F60.7	Dependent Personality Disorder

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

POSTTRAUMATIC STRESS DISORDER (PTSD)

BEHAVIORAL DEFINITIONS

1. Has experienced a traumatic event that involved actual or threatened death or serious injury and caused a reaction of intense fear or helplessness.
2. Experiences recurrent intrusive memories or dreams of the traumatic event.
3. Acts or feels as if the trauma were recurring.
4. Experiences intense distress when exposed to reminders of the trauma.
5. Avoids stimuli that trigger traumatic memories.
6. Experiences psychic numbing to avoid feelings or thoughts of the trauma.
7. Has periods of disassociation, or inability to remember parts of the trauma.
8. Reports persistent symptoms of increased autonomic arousal (e.g., difficulty sleeping, irritability, anger outbursts, difficulty concentrating, hypervigilance, exaggerated startle response).
9. Expresses verbal threats or displays physically violent behavior.
10. Demonstrates a pattern of intimate relationship, coworker, and authority conflict.
11. Engages in addictive behavior as an escape from pain that is associated with the trauma.

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LONG-TERM GOALS

1. Develop and implement effective coping skills to carry out normal responsibilities, participate constructively in relationships, and bring addiction under control.
2. Maintain a program of recovery that is free of addiction and post-traumatic stress.
3. Resolve the emotional effects of the past trauma, and terminate its negative impact on current behavior.
4. Reduce the negative impact that the traumatic event has had on many aspects of life and return to the pretrauma level of functioning.
5. Understand posttraumatic stress symptoms and how they led to addiction in a self-defeating attempt to cope.
6. Terminate the destructive behaviors that serve to maintain escape and denial, while implementing behaviors that promote healing, acceptance of the past events, and responsible living.

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SHORT-TERM OBJECTIVES

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

THERAPEUTIC INTERVENTIONS

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

	assessment instrument if desired (see the Anxiety Disorders Interview Schedule–Adult Version).
2. Complete psychological tests designed to assess and/or track the nature and severity of PTSD symptoms. (3)	3. Administer or refer the client for administration of psychological testing or objective measures of the PTSD symptoms and/or other comorbidity (e.g., Minnesota Multiphasic Personality Inventory—2; Impact of Event Scale–Revised; PTSD Symptom Scale; or Posttraumatic Stress Diagnostic Scale); discuss results with the client; readminister as needed to assess treatment response).
3. Verbalize the symptoms of depression, including any suicidal ideation. (4)	4. Assess the client's depth of depression and suicide potential and treat appropriately, taking the necessary safety precautions as indicated (see the "Unipolar Depression" and "Suicidal Ideation" chapters in this *Planner*).
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)	5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
	6. Assess the client for evidence of research-based correlated

	disorders (e.g., oppositional defiant behavior with 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).
	7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
	8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. List times that PTSD symptoms led to addictive behavior and addictive behavior led to traumatic events. (9)	9. Assign the client to list times when symptoms of PTSD led to addictive behavior and when addictive behavior led to traumatic events (or assign "Coping With Addiction and PTSD or Other Anxiety Disorders" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
6. List the ways in which a 12-step program can assist in recovery	10. Teach the client about the 12-step recovery program and

from PTSD and addictive behavior. (10)	discuss how it can assist in his/her recovery.
7. Cooperate with an evaluation by a physician for psychotropic medication. (11, 12)	11. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate.
	12. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.
8. Verbalize an accurate understanding of PTSD and how it develops. (13)	13. Discuss how PTSD results from exposure to trauma; results in intrusive recollection, unwarranted fears, anxiety, and a vulnerability to other negative emotions such as shame, anger, and guilt; and results in avoidance of thoughts, feelings, and activities associated with the trauma.
9. Verbalize an understanding of the rationale for treatment of PTSD. (14, 15)	14. Educate the client about how effective treatments for PTSD help address the cognitive, emotional, and behavioral consequences of PTSD using cognitive and behavioral therapy approaches (see *Trauma Therapy in Context* by McMakin et al.).
	15. Assign the client to read psychoeducational chapters of books or treatment manuals on PTSD that explain its features and development (e.g., *Overcoming Post-Traumatic Stress Disorder* by Smyth; *Reclaiming Your Life From a Traumatic Experience* by Rothbaum, Foa, and Hembree; *Getting Through the Day: Strategies for Adults Hurt as Children* by Napier).

10. Learn and implement calming and coping strategies to manage challenging situations related to trauma. (16, 17)

16. Teach the client strategies from Stress Inoculation Training such as relaxation, breathing control, covert modeling (i.e., imagining the successful use of the strategies) and/or role-playing (i.e., with therapist or trusted other) for managing fears until a sense of mastery is evident (see *Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults With Posttraumatic Stress Disorder* by Meichenbaum).

17. Assign the client to read about calming and coping strategies in books or treatment manuals on PTSD (e.g., *I Can't Get Over It* by Matsakis, or assign "Safe and Peaceful Place Meditation" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

11. Participate in Cognitive Processing Therapy to process the trauma and reduce its impact. (18, 19, 20, 21)

18. Use a Cognitive Processing Therapy approach, beginning with assigning the client to write a description of the meaning of the traumatic event (i.e., the impact statement); ask the client to read and discuss the impact statement (see *Posttraumatic Stress Disorder* by Resick, Monson, and Rizvi; *Cognitive Processing Therapy for Rape Victims* by Resick and Schnicke).

19. Teach the client the relationship between thoughts, behaviors, and emotions associated with the trauma.

20. Ask the client to write a detailed description of the traumatic event and read the statement in session (or assign "Share the Painful Memory" in the *Adult*

	Psychotherapy Homework Planner by Jongsma); use cognitive therapy techniques to question biased thoughts and beliefs and explore unbiased alternatives; repeat this process until a shift from biased to unbiased thinking is evident.
	21. Ask the client to rewrite a description of the event, but now reflecting new thoughts and beliefs; discuss this restructured version of the event reinforcing the new beliefs; assess and address themes common to PTSD (e.g., safety, trust, power, control, esteem, and intimacy).
12. Participate in Cognitive Therapy to help identify, challenge, and replace biased, negative, and self-defeating thoughts resulting from the trauma. (22, 23, 24)	22. Using Cognitive Therapy techniques, explore the client's self-talk and beliefs about self, others, and the future that are a consequence of the trauma (e.g., themes of safety, trust, power, control, esteem, and intimacy); identify and challenge biases; assist him/her in generating appraisals that correct for the biases; test biased and alternative predictions through behavioral experiments.
	23. Assign the client to keep a daily log of automatic thoughts (e.g., "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to challenge distorted thinking patterns with reality-based thoughts and to generate predictions for behavioral experiments.
	24. Assign the client a homework exercise in which the client

identifies fearful self-talk; tests, though behavioral experiments, the predictions from these dysfunctional thoughts; and creates reality-based alternatives. Review and reinforce success while problem-solving obstacles toward sustaining positive change (see *Overcoming Post-Traumatic Stress Disorder* by Smyth).

13. Participate in Prolonged Exposure Therapy to reduce fear and avoidance associated with the trauma. (25, 26, 27, 28, 29)

25. Direct and assist the client in constructing a fear and avoidance hierarchy of trauma-related stimuli.

26. Utilize in vivo exposure in which the client gradually exposes himself/herself to objects, situations, and places negatively associated with the trauma.

27. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (see "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma; or *Overcoming Post-Traumatic Stress Disorder* by Smyth); review and reinforce progress, problem-solve obstacles.

28. Utilize imaginal exposure to process memories of the trauma, at a client-chosen level of detail, for an extended period of time (e.g., 90 minutes); repeat in future sessions until distress reduces and stabilizes (see *Prolonged Exposure Therapy for PTSD* by Foa, Hembree, and Rothbaum; or *Posttraumatic Stress Disorder* by Resick, Monson, and Rizvi).

	29. Assign the client a homework exercise in which he or she does self-directed exposure to the memory of the trauma. EBP
14. Learn and implement personal skills to manage challenging situations related to trauma. (30) EBP	30. Use techniques from Stress Inoculation Training (e.g., covert modeling [i.e., imagining the successful use of the strategies], role-play, practice, and generalization training) to teach the client-tailored skills (e.g., calming and coping skills) for managing fears, overcoming avoidance, and increasing present-day adaptation (see *Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Posttraumatic Stress Disorder (PTSD)* by Meichenbaum). EBP
15. Learn and implement guided self-dialogue to manage thoughts, feelings, and urges brought on by encounters with trauma-related situations. (31) EBP	31. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenges its biases, copes with engendered feelings, overcomes avoidance, and reinforces his/her accomplishments (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce progress, problem-solve obstacles. EBP
16. Participate in Eye Movement Desensitization and Reprocessing (EMDR) to reduce emotional distress related to traumatic thoughts, feelings, and images. (32) EBP	32. Utilize EMDR to reduce the client's emotional reactivity to the traumatic event and reduce PTSD symptoms (see *Eye Movement Desensitization and Reprocessing* by Shapiro). EBP
17. Participate in Acceptance and Commitment Therapy (ACT) to reduce the impact of the traumatic event. (33, 34, 35, 36)	33. Use an ACT approach to PTSD to help the client experience and accept the presence of troubling thoughts and images without being overly impacted by them,

and commit his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

34. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing but not reacting to non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [audio CD] by Zabat-Zinn).
35. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.
36. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems* by Follette and Pistorello; *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* by Najavits; *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy* by Hayes).

18. Acknowledge the need to implement anger control techniques; learn and implement anger management techniques. (37, 38)

37. Assess the client for instances of poor anger management that have led to threats or actual violence that caused damage to property and/or injury to people

	(or assign "Anger Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	38. Teach the client anger management techniques (see the "Anger" chapter in this *Planner*).
19. Learn and implement Compassionate Mind Training approach for addressing shame and self-disparagement. (39)	39. Use Compassionate Mind Training to help the client identify and change self-attacking and personal shaming resulting from the trauma (see *Focused Therapies and Compassionate Mind Training for Shame and Self-Attacking* by Gilbert and Irons).
20. Sleep without being disturbed by dreams of the trauma. (40, 41)	40. Using progressive relaxation, biofeedback, or hypnosis, teach the client how to relax; assign him/her to relax twice a day for 10 to 20 minutes.
	41. Monitor the client's sleep pattern and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma and see the "Sleep Disturbance" chapter in this *Planner*).
21. Turn posttraumatic stress and addiction over to a higher power each day. (42, 43)	42. Teach the client about the 12-step recovery program's concept of a higher power, and how this can be used in recovery (e.g., attend regular religious activities, meet weekly with a spiritual advisor, practice regular prayer and meditation).
	43. Using a 12-step recovery program's Step 3 exercise, teach the client how to turn problems over to a higher power; discuss how he/she felt using the step with perpetrators of past painful

events, reinforcing success and redirecting for failure.

22. Develop a written personal recovery plan that details the steps to follow to maintain abstinence from addictive behavior and to recover from posttraumatic stress. (44, 45)

44. Help the client to develop a personal recovery plan that includes attending recovery group meetings regularly, getting a sponsor, taking medications as directed, and having follow-up visits with therapist or doctor.

45. Assist the client in listing reasons why he/she should faithfully adhere to a recovery plan.

23. Family members verbalize what each can do to assist the client in recovery. (46, 47)

46. Discuss with family members the connection between PTSD and addictive behavior.

47. In a family session, review what each member can do to assist the client in recovery.

24. Complete a survey to assess the degree of satisfaction with treatment. (48)

48. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Major Depressive Disorder
	309.81	Posttraumatic Stress Disorder
	300.14	Dissociative Identity Disorder
	300.6	Depersonalization Disorder
	300.15	Dissociative Disorder NOS
	995.52	Physical Abuse of Child (victim)
	995.81	Physical Abuse of Adult (victim)

	995.83	Sexual Abuse of Adult (victim)
	995.53	Sexual Abuse of Child (victim)
	V61.21	Sexual Abuse of Child
	V61.10	Sexual Abuse of Adult (by partner)
	V62.83	Sexual Abuse of Adult (by person other than partner)
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
309.81	F43.10	Posttraumatic Stress Disorder
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.89	Other Specified Dissociative Disorder
300.15	F44.9	Unspecified Dissociative Disorder
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
995.81	T74.11XA	Spouse or Partner Violence, Physical, Confirmed, Initial Encounter
995.81	T74.11XD	Spouse or Partner Violence, Physical, Confirmed, Subsequent Encounter
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter

305.00	F10.10	Alcohol Use Disorder, Mild
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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

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

PSYCHOSIS

BEHAVIORAL DEFINITIONS

1. Exhibits bizarre content of thought (e.g., delusions of grandeur, persecution, reference, influence, control, somatic sensations, infidelity).
2. Verbalizes illogical form of thought and/or speech (e.g., loose association of ideas in speech, incoherence; illogical thinking; vague, abstract, or repetitive speech; neologisms, perseverations, clanging).
3. Reports perceptual disturbance (e.g., hallucinations, primarily auditory but occasionally visual or olfactory).
4. Demonstrates disturbed affect (e.g., blunted, none, flattened, or inappropriate).
5. Expresses lost sense of self (e.g., loss of ego boundaries, lack of identity, blatant confusion).
6. Presents with diminished volition (e.g., inadequate interest, drive, or ability to follow a course of action to its logical conclusion; pronounced ambivalence toward or cessation of goal-directed activity).
7. Experiences relationship withdrawal (e.g., withdrawal from involvement with external world and preoccupation with egocentric ideas and fantasies, feelings of alienation).
8. Demonstrates psychomotor abnormalities (e.g., marked decrease in reactivity to environment; various catatonic patterns, such as stupor, rigidity, excitement, posturing, or negativism; unusual mannerisms or grimacing).
9. Displays inability to adequately care for own physical needs, which is potentially harmful to self.
10. Presents as potentially harmful to self or others.
11. Engages in substance abuse, which exacerbates psychotic symptoms.

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LONG-TERM GOALS

1. Control or eliminate active psychotic symptoms, such that supervised functioning is positive and medication is taken consistently.
2. Significantly reduce or eliminate hallucinations and/or delusions.
3. Eliminate acute, reactive, psychotic symptoms and return to normal functioning in affect, thinking, and relating.
4. Stabilize functioning adequate to allow treatment in outpatient setting.
5. Develop adaptive methods to cope with symptoms, and seek treatment when necessary.
6. Terminate substance abuse.
7. Achieve and maintain an active, personally effective recovery approach.

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SHORT-TERM OBJECTIVES

1. Accept and understand that distressing symptoms are due to a mental illness and to addictive behavior. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Determine if the client's psychosis is of a brief, reactive nature or is chronic, with prodromal and reactive elements.
2. Explore the client's family history for serious mental illness and addictive behavior.
3. Evaluate the severity of the client's addiction, as well as psychotic symptoms; refer to emergency service if the client is a danger to self or others or symptom severity suggests possible inpatient care.

2. Comply with examinations to evaluate the possible contribution of a medical condition (e.g., tumor, dementia). (4, 5)

3. Complete psychological testing or objective questionnaires for assessing psychosis. (6)

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

4. Refer to a physician for medical evaluation to rule out psychotic symptoms due to a general medical condition.

5. Perform or refer for neuropsychological testing to assess symptoms consistent with possible contribution of a general medical condition.

6. Administer to the client psychological instruments designed to objectively assess psychosis (e.g., Minnesota Multiphasic Personality Inventory—2, Psychiatric Research Interview for Substance and Mental Disorders); give the client feedback regarding the results of the assessment.

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).

5. Report a decrease in psychotic symptoms through the consistent use of psychotropic medications. (11, 12)

11. Educate the client about the use and expected benefits of psychotropic medications; encourage consistent taking of prescribed medications (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma).

12. Monitor the client's medication compliance, effectiveness, and side effect risk (e.g., tardive dyskinesia, muscle rigidity, dystonia, metabolic effects such as weight gain).

6. Participate with family and/or significant others in a therapy designed to improve quality of life of all members and facilitate personal recovery. (13)

13. Conduct a family-based intervention beginning with psychoeducation emphasizing the biological nature of psychosis, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, early episode intervention, and social support (see *Family Care of Schizophrenia* by Falloon, Boyd, and McGill).

7. Learn and implement effective communication skills with family and/or significant others. (14, 15)

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

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

8. Implement problem-solving skills with family and/or significant others to address problems that arise. (16, 17)

16. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.

17. Use cognitive behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family

	problem-solving skills (i.e., defining the problem constructively and specifically; brainstorming solution options; evaluating the pros and cons of the options; choosing an option and implementing a plan; evaluating the results; and adjusting the plan).
9. Complete exercises between sessions to practice newly learned personal and interpersonal skills. (18)	18. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills; process results in session toward effective use; problem-solve obstacles (assign "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session.
10. Develop and participate in a family relapse prevention and management plan in the event that psychotic symptoms return. (19)	19. 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.
11. Participate in a psychoeducational program with other families. (20)	20. Refer the family to a multigroup family psychoeducational program (see *Multifamily Groups in the Treatment of Severe Psychiatric Disorders* by McFarlane).
12. Identify internal and environmental triggers of psychotic symptoms. (21)	21. Help the client identify specific behaviors, situations, thoughts, and feelings associated with symptom exacerbations.

13. Identify current reactions to symptoms and their impact on self and others. (22, 23)

22. Help the client identify his/her emotional and behavioral reactions as well as other consequences of psychotic symptoms toward the goal of increasing his/her understanding of these reactions and how they impact functioning adaptively or maladaptively such as an increase in addictive behaviors, withdrawal leading to isolation and loneliness, or paranoid accusations leading to negative reactions of others that falsely support the delusion (or assign "Coping With Addiction and Schizophrenia Spectrum Disorders" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

23. Assess adaptive and maladaptive strategies that the client is using to cope with psychotic symptoms; reinforce adaptive strategies.

14. Learn and implement skills that increase personal effectiveness and resistance to subsequent psychotic episodes. (24, 25, 26)

24. Tailor cognitive-behavioral strategies so the client can restructure psychotic cognition, learn effective personal and interpersonal skills, and develop coping and compensation strategies for managing psychotic symptoms (see *Treating Complex Cases: The Cognitive Behavioural Therapy Approach* by Tarrier, Wells, and Haddock).

25. Desensitize the client's fear of his/her hallucinations by allowing or encouraging him/her to talk about them, their frequency, their intensity, and their meaning (or assign "What Do You Hear and See?" in the *Adult Psychotherapy*

	Homework Planner by Jongsma); provide a reality alternative view of the world.
	26. Use education, modeling, role-play, reinforcement, and other cognitive-behavioral strategies to teach the client coping and compensation strategies for managing psychotic symptoms (e.g., calming techniques; attention switching and narrowing; realistic self-talk; realistic attribution of the source of the symptom; and increased adaptive personal and social activity).
15. Identify and change self-talk and beliefs that interfere with recovery. (27, 28)	27. Use Cognitive Therapy techniques to explore biased self-talk and beliefs that contribute to delusional thinking; assist the client in identifying and challenging the biases, generating alternative appraisals that correct biases, building confidence, and improving adaptation.
	28. Assign the client homework exercises in which he/she identifies biased self-talk, creates reality-based alternatives, and tests them in his/her experience; review and reinforce success, providing corrective feedback toward facilitating sustained, positive change (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).
16. Verbalize an understanding for the need to learn new and improved social skills. (29)	29. Provide a rationale for social skills training that communicates the benefits of improved social interactions and decreased negative social actions.

17. Participate in individual or group therapy focused on improving social effectiveness. (30)

30. Provide or refer the client to individual or group social skills training that employs cognitive behavioral strategies (e.g., education, modeling, role-play, practice, reinforcement, and generalization) to teach the client relevant social skills (e.g., conversation, assertiveness, conflict resolution) to improve his/her ability to attain and maintain social relationships (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. Read about social skills training in books or manuals recommended by the therapist. (31)

31. Use prescribed reading assignments from books or treatment manuals consistent with therapeutic skill being taught to facilitate the client's acquisition of it (e.g., *Your Perfect Right* by Alberti and Emmons for assertiveness skills; *Conversationally Speaking* by Garner for conversational skills).

19. Practice and strengthen skills learned in therapy. (32)

32. Prescribe in- and between-session exercises that allow the client to practice new skills, reality test and challenge his/her maladaptive beliefs, and consolidate a new approach to adaptive functioning and symptom management; review; reinforce positive change; problem-solve obstacles toward consolidating the client's skills.

20. Participate in a therapy to practice mental tasks and learn strategies to improve mental, emotional, and social functioning. (33)

33. Provide or refer the client to a Cognitive Remediation/ Neurocognitive Therapy program that uses repeated practice of cognitive tasks and/or

strategy training to restore cognitive function and/or teach compensatory strategies for cognitive impairments and improve cognitive, emotional, and social functioning (see *Cognitive Remediation Therapy for Schizophrenia* by Wykes and Reeder; *Cognitive Remediation for Psychological Disorders* by Medalia, Revheim, and Herlands).

21. Participate in a training program to build job skills. (34)

34. Refer client to a Supported Employment program to build occupational skills and improve overall functioning and quality of life.

22. Decrease substance abuse as a precipitating trigger for psychotic symptoms. (35, 36)

35. Use a Motivational Interviewing approach toward engaging the client in the process of discontinuing substance use, including drugs, alcohol, nicotine, and caffeine (see the "Substance Use Disorders" chapter of this *Planner*).

36. Refer the client to a substance abuse treatment program.

23. Verbalize the acceptance of mental illness and willingness to engage in recovery, decreasing feelings of stigmatization. (37)

37. Encourage the client to express his/her feelings related to acceptance of the mental illness and engagement in recovery; reinforce thoughts and actions that strengthen the client's engagement in the recovery process.

24. Attend a support group for others with severe mental illness. (38)

38. Refer the client to a support group for individuals with a mental illness with the goal of helping consolidate his/her new approach to recovery.

25. Implement a plan for constructive activities for each day. (39, 40)

39. Prompt the client to complete basic activities of daily living (ADLs) to promote caring for

	his/her own basic needs; review and reinforce for progress.
	40. Assign the client the task of daily preparing a list of activities that are planned (or possibly assign "Planning a Stable Life" in the *Addiction Treatment Homework Planner* by Finley and Lenz); review and reinforce for progress.
26. Attend recreational therapy activities, and follow the rules of interaction while reporting feeling nonthreatened. (41)	41. Direct the client to attend recreational therapy activities that are nonthreatening, simple to master, and encourage a low level of social interaction; reinforce for success and redirect for failure.
27. Attend an occupational therapy group, and participate with actions that show initiative, logic, follow-through, and abstract reasoning. (42)	42. Direct occupational therapy activity that diverts the client from internal cognitive focus and provides for structured social interaction and a sense of accomplishment on the completion of a task.
28. Engage in an art therapy group discussion to identify feelings, enhance reality focus, and increase social contact. (43, 44)	43. Conduct an art therapy group in which the client is encouraged to express feelings through various art media.
	44. Lead a group discussion, in which the client is encouraged to share the meaning of his/her artwork.
29. Sleep in a normal pattern of 6 to 9 hours per night without agitation, fears, or disruption. (45)	45. Direct the client to sleep at expected times, and reinforce him/her for compliance.
30. Verbalize an understanding and acceptance of the need for a structured, supervised living situation after discharge for intensive treatment. (46)	46. Arrange for an appropriate level of supervised, residential care for the client (or assign "Planning a Stable Life" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

31. Complete a survey to assess the degree of satisfaction with treatment. (47)

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47. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	291.x	Alcohol-Induced Psychotic Disorder
	292.xx	Other (or Unknown) Substance-Induced Disorder
	295.xx	Schizophrenia
	295.40	Schizophreniform Disorder
	295.70	Schizoaffective Disorder
	296.xx	Major Depressive Disorder
	296.xx	Bipolar I Disorder
	297.1	Delusional Disorder
	298.8	Brief Psychotic Disorder
	295.40	Schizophreniform Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
291.9	F10.259	Alcohol-Induced Psychotic Disorder, With Moderate or Severe Use Disorder
297.1	F22	Delusional Disorder
298.8	F23	Brief Psychotic Disorder
295.30	F20.9	Schizophrenia
295.40	F20.40	Schizophreniform Disorder
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	33.x	Major Depressive Disorder, Recurrent Episode

296.xx	F31.xx	Bipolar I Disorder
298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

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

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

RELAPSE PRONENESS

BEHAVIORAL DEFINITIONS

1. Reports a history of multiple addiction treatment attempts and subsequent relapse.
2. Frequently expresses negative emotions, increasing the risk for continued addiction.
3. Friends or family members engage in addictive behavior.
4. Describes interpersonal conflicts, which increase the risk for relapse.
5. Reports experiencing social pressure, which encourages substance abuse.
6. Has never worked a program of recovery long enough to maintain abstinence.
7. Has a history of mental illness, increasing risk for relapse.
8. Reports many attempts at sobriety without treatment, but these have resulted in relapse.

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LONG-TERM GOALS

1. Maintain freedom from addiction without experiencing relapse.
2. Develop coping skills to use when experiencing high-risk situations and/or craving.
3. Resolve interpersonal conflicts and learn healthy communication skills.
4. Develop a new peer group that is supportive of recovery.
5. Learn refusal skills for use when tempted into addictive behavior.

6. Practice a program of recovery that includes regular attendance at recovery group meetings, working with a sponsor, and helping others in recovery.

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SHORT-TERM OBJECTIVES

1. Write a detailed chemical use history, describing treatment attempts and the specific situations surrounding relapse. (1)
2. Complete psychological testing or objective questionnaires for assessing addiction relapse. (2)
3. Verbalize the powerlessness and unmanageability that result from addiction and relapse. (3)
4. Verbalize that continued alcohol/drug abuse meets the 12-step program concept of *insanity*. (4)

THERAPEUTIC INTERVENTIONS

1. Assign the client to write a chemical use history, describing his/her attempts at recovery and the situations surrounding relapse.
2. Administer to the client psychological instruments designed to objectively assess addiction relapse (e.g., Substance Abuse Relapse Assessment); give the client feedback regarding the results of the assessment; re-administer as needed to assess treatment response.
3. Using a 12-step recovery program's Step 1 exercise, help the client to see the powerlessness and unmanageability that result from addiction and relapse (or assign the client to complete the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
4. Using a 12-step recovery program's Step 2 exercise, help the client to see the insanity of his/her disease, then teach him/her that a higher power

	can restore him/her to sanity (or assign the client to complete the Step 1 exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
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. (5, 6, 7, 8)	5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change). 6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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). 7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior. 8. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
6. Verbalize reasons why it is essential to work a daily program of recovery to maintain abstinence. (9, 10, 11)	9. Help the client to understand the reasons he/she keeps relapsing, such as failure to work a daily program of recovery, failure to go to meetings, poor coping skills for high-risk situations, mental illness, interpersonal problems, poor recovery environment (or assign "Early Warning Signs of Relapse" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	10. Help the client to understand why it is essential to implement a daily program of recovery to maintain abstinence.
	11. Using the client's relapse history, help him/her to understand the reasons why his/her recovery program failed.
7. List ways in which a higher power can assist in recovery from addiction. (12, 13)	12. Teach the client how to use the 12-step recovery program's Step 3, and assign him/her to practice turning problems over to a higher power each day; have the client record each situation and discuss these with the primary therapist (or assign the client to complete the Step 2 and Step 3

exercises from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

13. Teach the client how a higher power can assist in recovery (e.g., attending religious activities, practicing regular prayer and meditation).

8. Make a written plan to increase reinforcement when attending recovery group meetings. (14, 15, 16)

14. Probe the reasons why the client discontinues going to 12-step recovery program meetings consistently.

15. Help the client to develop a plan that will increase the rewards obtained at recovery groups (e.g., concentrate on helping others, go for coffee after the meeting, socialize, stick with the winners).

16. Assign the client to a 12-step recovery program contact person, and have the client begin to attend recovery group meetings with him/her regularly; encourage both individuals to make the outing fun, rather than a boring obligation.

9. Renew commitment to abstain from the use of mood-altering drugs. (17)

17. After a review of the negative consequences of relapse, develop an abstinence contract with the client regarding the termination of the use of his/her drug (or assign "Substance Abuse Negative Impact versus Sobriety's Positive Impact" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the client's feelings related to the commitment.

10. Verbalize an understanding of why relapse continues to occur. (18, 9, 19)

18. Teach the client the high-risk situations that lead to relapse (e.g., negative emotions, social pressure, interpersonal conflict,

positive emotions, tests of personal control), or use a 12-step recovery program's relapse prevention exercise to help the client uncover his/her triggers for relapse (see "Relapse Triggers" in the *Adult Psychotherapy Homework Planner* by Jongsma or *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson). EBT

9. Help the client to understand the reasons he/she keeps relapsing, such as failure to work a daily program of recovery, failure to go to meetings, poor coping skills for high-risk situations, mental illness, interpersonal problems, poor recovery environment (or assign "Early Warning Signs of Relapse" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

19. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse. EBT

EBT 11. Implement a plan to manage each identified situation that represents a high risk for relapse. (20, 21)

20. Help the client to make a written plan that details the coping skills (e.g., go to a meeting, call a sponsor, call the 12-step recovery program hotline, call the counselor, talk to someone) to use when in a high-risk situation (e.g., negative emotions, social pressure, interpersonal conflict, strong positive emotions, tests of personal control) (or assign "Personal Recovery Planning" in the *Addiction Treatment*

	Homework Planner by Finley and Lenz).
	21. Review the client's implementation of coping skills for high-risk situations in his/her daily life; reinforce success and redirect for failure.
12. Identify, challenge, and replace destructive self-talk with positive, strength building self-talk. (22, 23)	22. Use cognitive therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.
	23. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success.
13. Learn and implement personal coping strategies to manage urges to lapse back into chemical use. (24)	24. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.
14. Learn and implement personal coping skills to prevent and/or manage common day-to-day challenges and build confidence in managing them without the use of substances. (25, 26, 27, 28, 29, 30)	25. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build social and/or communication skills to manage these challenges without the use of substances

(or assign the client to complete *Overcoming Your Alcohol or Drug Problem* by Daley and Marlatt).

26. Teach the client adaptive assertive communication skills such as active listening, using "I messages," reflecting, and sharing feelings (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma).

27. Teach the client conflict-resolution skills; using modeling, role-playing, and behavior rehearsal, have him/her practice handling conflict in high-risk situations (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

28. Using modeling, role-playing, and behavior rehearsal, teach the client how to say no to alcohol/drugs; practice refusal in several high-risk situations.

29. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

30. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (see *Relapse Prevention: Maintenance Strategies in the*

	Treatment of Addictive Behaviors by Marlatt and Donovan).
15. Identify and make changes in social relationships that will support recovery. (31)	31. Review the negative influence of the client continuing his/her alcohol-related friendships (drug buddies) and assist him/her in making a plan to develop new sober relationships including sobriety buddies; revisit routinely and facilitate toward development of a new social support system (or assign "What Do I Need and How Do I Get It?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
16. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (32, 33)	32. Assist the client in planning social and recreational activities that are free from association with substance abuse; revisit routinely and facilitate toward development of a new set of activities (or assign the client to complete the "Relapse Prevention" exercise from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
	33. Plan household, work-related, and/or other free-time projects that can be accomplished to build the client's self-esteem and self-concept as clean and sober.
17. Verbalize how the living situation contributes to chemical dependence and acts as a hindrance to recovery. (34)	34. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process with the client toward identifying therapeutic changes.
18. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (35)	35. Facilitate development of a plan for the client to change his/her living situation to foster recovery; revisit routinely and facilitate toward accomplishing a

	positive change in living situation (or assign "Assessing My Environment" in the *Addiction Treatment Homework Planner* by Finley and Lenz). EBP
EBP 19. Identify problems with intimate and family relationships that may be a hindrance to recovery. (36)	36. Assist the client in problem-solving issues in intimate or family relationships toward the goal of changes that promote recovery. EBP
EBP 20. Cooperate with an examination by a physician to see if pharmacological intervention is warranted. (37)	37. Refer the client to a physician to examine the client, order medications as indicated, titrate medications, and monitor for side effects. EBP
EBP 21. Take all medication as directed, and report as to the effectiveness and side effects. (38, 39)	38. Monitor the client's psychotropic medication for compliance, effectiveness, and side effects. EBP
	39. Direct the staff to administer medications as ordered by the physician and to monitor the psychotropic medications for compliance, effectiveness, and side effects. EBP
22. Agree to enter the structured continuing-care treatment setting that is necessary to maintain abstinence. (40)	40. Help the client to decide on an aftercare placement that is structured enough to help him/her maintain abstinence (e.g., halfway house, group home, outpatient treatment, day care, partial hospitalization).
23. Develop a written personal recovery plan. (41)	41. Help the client to develop a written continuing care plan that includes honesty, attending recovery group meetings regularly, getting a sponsor, and any other treatment that is needed to maintain abstinence (or assign "Relapse Prevention Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

24. Complete a survey to assess the degree of satisfaction with treatment. (42)

42. Administer a survey to assess the client's degree of satisfaction with treatment.

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	304.40	Amphetamine Dependence
	305.70	Amphetamine Abuse
	304.30	Cannabis Dependence
	305.20	Cannabis Abuse
	304.20	Cocaine Dependence
	305.60	Cocaine Abuse
	305.1	Nicotine Dependence
	304.00	Opioid Dependence
	305.50	Opioid Abuse
	312.8	Conduct Disorder
	309.81	Posttraumatic Stress Disorder
	291.2	Alcohol-Induced Persisting Dementia
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	V71.01	Adult Antisocial Behavior
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.82	Avoidant Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.40	F15.20	Amphetamine-Type Substance Use Disorder, Moderate or Severe
305.70	F15.10	Amphetamine-Type Substance Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.1	F17.200	Tobacco Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
312.81	F91.1	Conduct Disorder, Childhood-Onset Type
312.32	F91.2	Conduct Disorder, Adolescent-Onset Type
309.81	F43.10	Posttraumatic Stress Disorder
291.2	F10.27	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type
291.1	F10.26	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type
V71.01	Z72.811	Adult Antisocial Behavior
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder
301.82	F60.6	Avoidant Personality Disorder

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

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

SELF-CARE DEFICITS—PRIMARY*

BEHAVIORAL DEFINITIONS

1. Presents with chronic chemical dependence that has eroded motivation and discipline necessary for adequate self-care.
2. Demonstrates substandard hygiene and grooming, as evidenced by strong body odor, disheveled hair, or dirty clothing.
3. Fails to use basic hygiene techniques (e.g., bathing, brushing teeth, washing clothes).
4. Presents with medical problems due to poor hygiene.
5. Maintains poor diet due to deficiencies in cooking, meal preparation, or food selection.
6. Has poor interaction skills, as evidenced by limited eye contact, insufficient attending, and awkward social responses.
7. Has inadequate knowledge or functioning in basic skills around the home (e.g., cleaning floors, washing dishes, disposing of garbage, keeping fresh food available).
8. Reports loss of relationships, employment, or other social opportunities due to poor hygiene and/or inadequate attention to grooming.

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* Most of the content of this chapter (with minor revisions) is taken from *The Severe and Persistent Mental Illness Treatment Planner*, by D. J. Berghuis and A. E. Jongsma, Jr., 2000, New York, NY: Wiley. Copyright © 2000 by D. J. Berghuis and A. E. Jongsma, Jr.

LONG-TERM GOALS

1. Discontinue substance abuse and increase functioning in self-care.
2. Understand the need for good hygiene and implement healthy personal hygiene practices.
3. Learn basic skills for maintaining a clean, sanitary living space.
4. Regularly shower or bathe, shave, brush teeth, care for hair, and use deodorant.
5. Experience increased social acceptance because of improved appearance and/or improved functioning in self-care.

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SHORT-TERM OBJECTIVES

1. Describe current functioning in self-care, and how this relates to substance abuse. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Request that the client prepare an inventory of positive and negative functioning regarding self-care, including the relationship between lack of self-care and substance abuse (or assign "Assessing Self-Care Deficits" and/or "Relating Self-Care Deficits to My Addiction" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
2. Ask the client to identify a trusted individual from whom he/she can obtain helpful feedback regarding daily hygiene and cleanliness; coordinate feedback from this individual to the client.
3. Assess the client's basic nutritional knowledge and skills,

usual diet, and nutritional deficiencies; refer to a dietitian, if necessary.

2. Complete or give permission for a significant other to complete a survey of the client's level of implementation of self-care skills. (4)

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

4. Administer to the client or a significant other an objective psychological instrument (e.g., Independent Living Scales) to assess the client's degree of implementation of self-care skills; give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could

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

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

4. Share the painful emotions related to self-care deficits. (9, 10)

9. Assist the client in expressing emotions related to impaired performance in self-care (e.g., embarrassment, depression, low self-esteem).

10. Ask the client to identify two painful experiences in which rejection was experienced (e.g., broken relationships, loss of employment) due to the lack of performance of basic self-care.

5. List five negative effects of substance abuse and of not giving enough effort to self-care. (11, 12)

11. Help the client to visualize or imagine the possible positive changes that could result from decreased substance abuse and increased attention to appearance and other aspects of self-care; assist in identifying five negative effects of the client not giving sufficient attention to self-care.

12. Review with the client the medical risks (e.g., dental

	problems, risk of infection, lice) that are associated with substance abuse, poor hygiene, or lack of attention to other aspects of self-care.
6. Verbalize insight into the secondary gain that is associated with decreased self-care functioning. (13)	13. Reflect the possible secondary gain (e.g., less involvement in potentially difficult social situations, low expectations from others, sympathy from others, etc.) that is associated with decreased attention given to self-care.
7 Prioritize those self-care areas upon which to focus effort and improve functioning. (14, 15)	14. Ask the client to identify or describe those self-care behaviors that are desired, but are not present in his/her current repertoire.
	15. Facilitate the client prioritizing the implementation of self-care behaviors or the learning of skills that are necessary to implement these behaviors.
8. Cooperate with a referral for an assessment of intelligence and neuropsychological deficits. (16)	16. Refer the client for an assessment of cognitive deficits (e.g., intellectual disability, brain damage) that may contribute to his/her lack of attention to self-care.
9. Participate in a remediation program to teach self-care skills. (17)	17. Recommend remediation programs to the client (e.g., a self-care skill-building group, didactic group, behavior-shaping program) that is focused on removing self-care deficits.
10. Acknowledge self-care deficits as a symptom of chronic chemical dependence or mental illness. (18)	18. Reflect or interpret poor performance in self-care as a result of chronic chemical dependence or psychiatric decompensation; assign "Relating Self-Care Deficits to My Addiction" in the *Addiction Treatment Homework Planner* by

	Finley and Lenz; share observations with the client, with caregivers, and with other staff.
11. Stabilize, through the use of psychotropic medications, psychotic and other severe and persistent mental illness symptoms that interfere with self-care. (19, 20, 21)	19. Arrange for an evaluation of the client by a physician to determine if a prescription for antipsychotic medication is warranted. 20. Educate the client about the proper use and the expected benefits of psychotropic medication. 21. Monitor the client for compliance with the prescribed psychotropic medication, and for its effectiveness and possible side effects.
12. Remediate the medical effects that have resulted from a history of a lack of self-care performance. (22, 23)	22. Arrange for a full physical examination of the client; encourage the physician to prescribe any necessary self-care remediation treatment. 23. Refer the client to a dentist to determine dental treatment needs; coordinate ongoing dental treatment.
13. Implement skills that are related to basic personal hygiene on a consistent, daily basis. (24, 25, 26, 27)	24. Provide the client with written or video educational material for basic personal hygiene skills (e.g., *The Complete Guide to Better Dental Care* by Taintor and Taintor, or the *American Medical Association Family Medical Guide* by the American Medical Association). 25. Refer the client to a designated staff for one-to-one training in basic hygiene needs and techniques. 26. Conduct or refer the client to a psychoeducational group for teaching personal hygiene skills;

use the group setting to help teach the client to give and receive feedback about hygiene skill implementation.

27. Encourage and reinforce the client for performing basic hygiene skills on a regular schedule (e.g., at the same time and in the same order each day).

14. Utilize a self-monitoring system to increase the frequency of regular use of basic hygiene skills. (28, 29)

28. Help the client to develop a self-monitoring program (e.g., a check-off chart for self-care needs).

29. Provide the client with regular feedback about progress in his/her use of self-monitoring to improve personal hygiene.

15. Utilize community resources to improve personal hygiene and grooming. (30, 31)

30. Review the use of community resources with the client (e.g., laundromat/dry cleaner, hair salon/barber) that can be used to improve personal appearance.

31. Coordinate for the client to tour community facilities for cleaning and pressing clothes, cutting and styling hair, or purchasing soap and deodorant, with an emphasis on increasing the client's understanding of this service and how it can be used.

16. Cooperate with treatment for substance abuse and/or mental illness that interferes with the ability to care for self. (32, 33, 34)

32. Assess the client for substance abuse or severe mental illness that exacerbates poor self-care performance (or assign "Relating Self-Care Deficits to My Addiction" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

33. Refer the client to Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other substance abuse treatment

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

34. Provide integrated, coordinated mental health and substance abuse treatment services.

17. Implement basic skills for running and maintaining a home or apartment. (35, 36)

35. Facilitate family members, friends, and caregivers who are willing to train the client in basic housekeeping skills; monitor and reinforce the client's progress.

36. Teach the client basic housekeeping skills, utilizing references such as *Mary Ellen's Complete Home Reference Book* by Pinkham and Burg.

18. Implement basic cooking skills and eat nutritionally balanced meals daily. (37, 38)

37. Educate the client on basic cooking techniques (e.g., *The Good Housekeeping Illustrated Cookbook* by the editors of *Good Housekeeping* or *How to Cook Everything* by Bittman) or refer the client to a community-based education cooking class or seminar.

38. Monitor the client's follow-through regarding a dietitian's recommendations for changes in the client's cooking and eating practices.

19. Engage in physical exercise several times per week. (39, 40, 41, 42)

39. Refer the client to an activity therapist, or make recommendations regarding physical fitness activities that are available in the community or through health clubs.

40. Assist the client in setting specific exercise goals, and monitor his/her participation in exercise and physical fitness activities.

41. Provide educational material (e.g., *Fitness and Health* by Sharkey or *ACSM Fitness Book* by American College of Sports Medicine) to increase the client's knowledge of physical fitness needs.
42. Coordinate or facilitate membership for the client at a local health club or YMCA/YWCA.

20. Complete a survey to assess the degree of satisfaction with treatment. (43)

43. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	297.1	Delusional Disorder
	295.xx	Schizophrenia
	295.10	Schizophrenia, Disorganized Type
	295.30	Schizophrenia, Paranoid Type
	295.90	Schizophrenia, Undifferentiated Type
	295.60	Schizophrenia, Residual Type
	295.70	Schizoaffective Disorder
	296.xx	Bipolar I Disorder
	296.xx	Major Depressive Disorder
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	_____	_____
Axis II:	317	Mild Mental Retardation
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
297.1	F22	Delusional Disorder
295.90	F20.9	Schizophrenia
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
296.xx	F31.xx	Bipolar I Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
317	F70	Intellectual Disability, Mild

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

SELF-CARE DEFICITS—SECONDARY*

BEHAVIORAL DEFINITIONS

1. Has a history of addictive behavior and chronic mental illness, which leads to a lack of effective independent activities of daily living (IADLs; e.g., transportation, banking, shopping, use of community services, other skills necessary for living more independently).
2. Verbalizes anxiety regarding increase in IADLs.
3. Lacks knowledge of community resources to aid in recovery.
4. Fails to respond appropriately in emergency situations.
5. Chronic addiction, paranoia, psychosis, or other severe and persistent mental illness symptoms negatively affect ability to use community resources independently.
6. Lacks familiarity with daily living resources (e.g., banking, stores, other services).
7. Does not pay attention to and organize personal responsibilities, resulting in unpaid bills and/or missed appointments.
8. Fails to access community resources (e.g., 12-step groups, worship centers, libraries, recreational areas, businesses).
9. External restrictions have been placed on access to community resources due to chronic addiction and/or bizarre behaviors.
10. Has a history of allowing or expecting others to take responsibility for performing own IADLs.

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LONG-TERM GOALS

1. Develop a program of recovery and increase knowledge of community resources.
2. Timely, appropriate, and safe responses to emergency situations.
3. Participate in recovery and increase functioning independently.
4. Consistent use of available addiction recovery and/or mental health community resources.
5. Increased organization of and attention to daily routines, resulting in personal responsibilities being fulfilled.
6. Take responsibility for own IADLs to level of own potential, and develop resources for help from others.

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SHORT-TERM OBJECTIVES

1. Describe powerlessness and unmanageability over addiction and/or mental illness and over current functioning in performing IADLs and the negative affects of substance abuse. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Request that the client prepare an inventory of his/her positive and negative experiences with attempting to perform IADLs while addicted (or assign "Filling in Self-Care Gaps" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
2. Ask the client to identify two areas in which he/she has experienced success in recovery and in becoming more independent in the community.
3. Solicit from the client two areas in which addiction has led to

failure in becoming more independent.

2. Complete or give permission for a significant other to complete a survey of the client's IADLs. (4)

4. Administer to the client or a significant other an objective survey (e.g., Independent Living Scales) to assess the client's IADLs; give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.

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

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and

	factors that could offer a better understanding of the client's behavior.
	8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Identify barriers to recovery and to increasing IADLs. (9, 10, 11)	9. Solicit from the client two areas in which addiction has led to failure in becoming more independent.
	10. Examine problematic IADL areas with the client to identify any patterns of addictive behavior or cognitions that cause failure at independent functioning (or assign "Working Toward Interdependence" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	11. After obtaining the client's permission to release information, obtain feedback from family members, friends, and caregivers about the client's addiction and performance of IADLs.
5. Prioritize IADL areas upon which to focus effort and improve functioning. (12, 13)	12. Ask the client to identify or describe those IADLs that are desired but not present in current repertoire.

13. Assist the client in prioritizing IADLs and the skills that must be learned.

6. Apply for Supplemental Security Income (SSI) if necessary, and agree to work with a family or mental health community advocate. (14)

14. Help the client choose a family or mental health community advocate, and apply for SSI, if necessary.

7. Participate in remediation programs to teach IADL skills and recovery from addiction. (15)

15. Recommend programs to the client (e.g., skill-building groups, 12-step meetings, token economies, or behavior-shaping programs) that are focused on removing deficits of IADL performance.

8. Increase frequency and appropriateness of recovery activities and social interaction. (16, 17, 18)

16. Explore the client's anxiety regarding social contacts, participation at recovery group meetings, and increasing independence (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma).

17. Assist the client in learning the skills necessary for using appropriate social behavior in recovery (see the Social Anxiety chapter in this *Planner*).

18. Provide positive feedback and encouragement to the client's attempts to increase social interaction and participate in a program of recovery.

9. Develop and implement a regular schedule for performance of routine IADLs and recovery from addiction. (19, 20)

19. Aid the client in developing a specific schedule for completing IADLs (e.g., go to 12-step group on Thursday, arrange finances on Monday morning, go to grocery store on Tuesday).

20. Teach the client about situations in which he/she should break

	from his/her established routine (e.g., do banking on a different day due to holiday, do weekly cleaning one day earlier in order to attend desired social function).
10. Acknowledge IADL deficits as a symptom of chronic addiction being inadequately controlled or treated. (21, 22)	21. Educate the client about the expected or common symptoms of his/her addiction (e.g., persistent intoxication or drug abuse), which may negatively impact basic IADL functioning.
	22. Reflect or interpret poor performance in IADLs as an indicator of addiction relapse; share observations with the client, caregivers, and medical staff.
11. Comply with an evaluation by a physician for psychotropic medication, and take medication as prescribed. (23, 24, 25, 26, 27)	23. Arrange for an evaluation of the client by a physician for a prescription for psychotropic medications.
	24. Educate the client about the proper use and expected benefits of psychotropic medications, including naltrexone and acamprosate; model procedures for the procurement of medications, and identify a person to monitor medication compliance.
	25. Monitor the client's psychotropic medication compliance and its effectiveness and possible side effects; report any significant problems to the medical staff.
	26. Develop an agreement with the client regarding the level of responsibility and independence he/she must display to trigger a decrease in clinician's monitoring of medications.

27. Coordinate an agreement between the client, pharmacist, and clinician regarding circumstances that would trigger the transfer of medication monitoring back to the clinician (e.g., the client's failure to pick up monthly prescription, client trying to refill a prescription too soon).

12. Obtain necessary transportation to work, 12-step meetings, medical appointments, leisure opportunities, or other desired destinations. (28)

28. Brainstorm possible transportation resources with the client (e.g., public transportation, personal vehicle, agency resources, friends and family, walking, bicycling); encourage and reinforce the client's independent use of these resources.

13. Use public transportation in a safe, socially appropriate, and efficient manner. (29, 30, 31)

29. Familiarize the client with available public transportation options through discussion, written schedules, and accompanied use of community services.

30. Review typical expectations for using public transportation, including payment, time schedule, and social norms for behavior.

31. Ride with the client to various destinations on public transportation until he/she is adequately comfortable in doing so alone.

14. Identify, attain, and manage adequate sources of financial income. (32, 33)

32. Assist the client in identifying and attaining adequate sources of income or eligibility for welfare assistance.

33. Develop a budget with the client, based on resources and needs (or assign "Plan a Budget" in the *Adult Psychotherapy Homework Planner* by Jongsma).

15. Use banking resources to facilitate financial independence. (34, 35, 36)

34. Review procedures for and advantages of the use of banking systems to assist the client with IADLs, including increased security, financial organization, and convenience paying bills; caution the client about hazards related to banking (e.g., credit debt, overdrawn checking account charges).

35. Coordinate a helping relationship between specific bank staff and the client; with proper permission to release information, provide information to bank staff about the client's needs and disabilities.

36. Encourage the client to use specific staff at a specific bank branch in order to develop a more personal and understanding relationship.

16. Utilize the services of a choice of stores in the community. (37, 38)

37. Familiarize the client with retail resources available in his/her area through a review of newspaper advertisements and a tour of the business districts in the community.

38. Role-play situations that commonly occur while shopping at a store (e.g., getting a sponsor, asking for assistance, declining a pushy salesperson, returning a defective item); provide the client with feedback about his/her functioning in these situations.

17. Attend 12-step meetings and other support groups. (39, 40)

39. Review places, times, and locations of support groups for the client (e.g., 12-step meetings, religious groups, community agencies).

40. Go with the client to 12-step meetings and other groups at

which he/she is uncomfortable or uncertain, gradually decreasing support.

18. Identify and contact alternative resources before contacting emergency response staff. (41, 42, 43)

41. Teach the client the appropriate use of specific emergency service professionals, including their responsibilities and limitations.

42. Provide the client with an easy-to-read list of emergency telephone numbers.

43. Brainstorm alternative resources that are available to the client for use, instead of nuisance calls to emergency response staff (e.g., contact a support group member when lonely; instead of going to the emergency room, contact family first if feeling ill).

19. Request assistance from others when attempting to implement IADLs. (44, 45)

44. Ask the client to identify a list of personal resources that he/she can use for assistance in carrying out IADLs (e.g., family and friends, support group members, neighbors).

45. Role-play how to approach strangers for basic assistance (e.g., asking for directions); provide feedback to the client about his/her approach, personal hygiene or dress, and how appearance and manner affect the stranger's comfort level (see the "Social Anxiety" chapter in this *Planner*).

20. Complete or give permission to a significant other to complete a survey to assess the degree of satisfaction with treatment. (46)

46. Administer a survey to the client or significant other to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	291.2	Alcohol-Induced Persisting Dementia
	303.90	Alcohol Dependence
	304.80	Polysubstance Dependence
	297.1	Delusional Disorder
	295.xx	Schizophrenia
	295.70	Schizoaffective Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	_____	_____
	_____	_____
Axis II:	317	Mild Mental Retardation
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
291.2	F10.27	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type
291.1	F10.26	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
297.1	F22	Delusional Disorder
295.xx	F20.9	Schizophrenia
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
296.xx	F31.xx	Bipolar I Disorder

296.89	F31.81	Bipolar II Disorder
317	F70	Intellectual Disability, Mild

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

SELF-HARM

BEHAVIORAL DEFINITIONS

1. Demonstrates a maladaptive pattern of self-harm, manifested by cutting, burning, hitting self to cause physical injury and to control uncomfortable feelings.
2. Fails to stop or cut down use of self-harm once started, despite the verbalized desire to do so and the negative consequences of continued use.
3. Denies that self-harm is a problem, despite feedback from significant others that the use of self-harm is negatively affecting him or her and others.
4. Continues self-harm despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are caused by self-harming behavior.
5. Demonstrates increased tolerance for self-harm, as there is the need to use more self-harm to achieve the desired effect.
6. Exhibits increased negative feelings of anxiety and depression when going without self-harm for any length of time.
7. Has a history of hospitalizations for self-harm behavior.
8. Reports suspension of important social, recreational, or occupational activities because they interfere with self-harming behavior.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over self-harm, and participate in a recovery-based program.
2. Establish a sustained recovery, free from the use of all self-harming behavior.
3. Establish and maintain total abstinence from self-harm, while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary 12-step skills to maintain long-term sobriety from all mood-altering chemicals and self-harming behavior.
5. Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals and self-harm behavior.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Provide honest and complete information for a chemical dependence and self-harm biopsychosocial history. (1)	1. Complete a thorough family and personal biopsychosocial history that has a focus on addiction (e.g., family history of addiction and treatment, other substances used, progression of substance abuse, consequences of abuse) and self-harm (e.g., types of self-harm engaged in, environmental setting, whether self-harm is secret or shared, progression of degree, accompanying mood, frequency increasing, association with substance use, etc.).
2. Complete psychological testing or objective questionnaires for assessing substance dependence. (2)	2. Administer to the client psychological instruments designed to objectively assess self-harming behavior (e.g., Millon Clinical Multiaxial Inventory—III).

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

3. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

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

4. Cooperate with medical assessment and an evaluation of the necessity for pharmacological intervention. (7, 8)

7. Refer the client to a physician to perform a physical examination (include tests for HIV, hepatitis, and sexually transmitted diseases), assess the need for psychotropic medication for any mental/emotional comorbidities, and discuss the use of acamprosate (Campral), naltrexone (Revia, Vivitrol), or disulfiram (Antabuse) where applicable.

8. Refer the client to a pharmacology-based treatment/recovery program (e.g., acamprosate, naltrexone), where applicable.

5. Take prescribed medications as directed by the physician. (9, 10)

9. Physician will monitor the effectiveness and side effects of medication, titrating as necessary.

10. Staff will administer prescribed medications and monitor for effectiveness and side effects.

6. Attend didactic sessions and read assigned material in order to increase knowledge of addiction and self-harm behavior and the process of recovery. (11, 12, 13, 14)

11. Assign the client to attend a chemical dependence didactic series to increase his/her knowledge of the patterns and effects of chemical dependence and self-harm; ask him/her to identify several key points attained from each didactic and process these points with the therapist.

12. Assign the client to read a workbook describing evidence-based

	treatment approaches to addiction recovery (e.g., *Overcoming Your Alcohol or Drug Problem* by Daley and Marlatt); use the readings to reinforce key concepts and practices throughout therapy.
	13. Assign the client to read material on addiction (e.g., *Willpower's Not Enough* by Washton and Boundy; *The Addiction Workbook* by Fanning; or *Alcoholics Anonymous* by Alcoholics Anonymous World Services); process key points gained from the reading.
	14. Require the client to read the book *Narcotics Anonymous* by the World Service Office and gather five key points from it to process with the therapist.
7. Attend group therapy sessions to share thoughts and feelings associated with, reasons for, consequences of, feelings about, and alternatives to addiction and self-harm. (15, 16)	15. Assign the client to attend group therapy focused on addiction recovery and self-harm.
	16. Direct group therapy that facilitates the client sharing of causes for, consequences of, feelings about, and alternatives to addiction.
8. Verbally admit to powerlessness over mood-altering substances and self-harming behavior. (17)	17. Assign the client to complete a 12-step program's Step 1 paper admitting to powerlessness over mood-altering chemicals, and present it in group therapy or to therapist for feedback (see *The Alcoholism & Drug Abuse Client Workbook* by Perkinson).
9. List and discuss negative consequences resulting from or exacerbated by self-harm. (18, 19, 20)	18. Ask the client to make a list of the ways chemical use and self-harm has negatively impacted his/her life (or assign "Substance Abuse Negative Impact versus Sobriety's Positive Impact" in

	the *Adult Psychotherapy Homework Planner* by Jongsma); process the list in individual or group sessions.
	19. Confront the client's use of denial to minimize the severity of and negative consequences of substance abuse and self-harm behavior.
	20. Using the biopsychosocial history and the client's list of negative consequences of substance abuse and self-harm, assist him/her in understanding the need to stay in treatment.
10. Verbalize recognition that self-harm and chemical use was used to escape from stress or pain and resulted in negative consequences. (21)	21. Explore how self-harm was used to escape from stress, physical and emotional pain, and boredom; confront the negative consequences of this pattern.
11. List and discuss the negative emotions that were caused by or exacerbated by substance dependence and self-harm behavior. (22)	22. Probe the client's sense of shame, guilt, and low self-worth that has resulted from addiction and self-harm and its consequences.
12. List and discuss reasons to work on a plan for recovery from addiction. (23)	23. Assign the client to write a list of reasons to be abstinent from addiction (or assign "Making Change Happen" or "A Working Recovery Plan" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
13. List lies used to hide substance dependence and self-harm behavior. (24, 25)	24. Help the client see the dishonesty that goes along with addiction; ask him/her to list lies told to hide substance use (or assign the client to complete the "Honesty" exercise from *The Alcoholism & Drug Abuse Client Workbook* by Perkinson).
	25. Teach the client why honesty is essential to recovery.

14. Verbalize ways a higher power can assist in recovery. (26)

15. Identify and accept the need for substance abuse and self-harm treatment. (27)

16. Identify realistic goals for substance abuse and self-harm recovery. (28, 29, 30)

26. Teach the client about the Alcoholics Anonymous concept of a higher power and how this can assist in recovery (e.g., God can help with chronic pain or craving, regular prayer and meditation can reduce stress; or assign the client to complete the Step Two and Step Three exercises from *The Alcoholism & Drug Abuse Client Workbook* by Perkinson).

27. Conduct Motivational Interviewing to assess the client's stage of preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Motivational Interviewing* by Miller and Rollnick).

28. Assign the client to meet with an Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) member who has been working the 12-step program for several years and find out specifically how the program has helped him/her to stay sober; afterward, process the meeting.

29. Request that the client write out basic treatment expectations (e.g., physical changes, social changes, emotional needs) regarding sobriety and freedom from self-harm and process these with the clinician.

30. Emphasize the goal of substance abuse recovery and on the need for sobriety and freedom from self-harm, despite lapses or relapses.

17. Verbalize a commitment to abstain from the use of mood-altering drugs. (31)

18. Identify and make changes in social relationships that will support recovery. (32)

19. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (33, 34)

20. Verbalize how the living situation contributes to chemical dependence and self-harm and acts as a hindrance to recovery. (35)

21. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (36)

31. Develop an abstinence contract with the client regarding the termination of the use of his/her drug; process and self-harm the client's feelings related to the commitment.

32. Review the negative influence of the client continuing his/her alcohol-related friendships (drug buddies) and assist him/her in making a plan to develop new sober relationships including sobriety buddies; revisit routinely and facilitate toward development of a new social support system.

33. Assist the client in planning social and recreational activities that are free from association with substance abuse; revisit routinely and facilitate toward development of a new set of activities.

34. Plan household, work-related, and/or other free-time projects that can be accomplished to build the client's self-esteem and self-concept as clean and sober.

35. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence and self-harm (or assign "Assessing My Needs" in the *Addiction Treatment Homework Planner* by Finley and Lenz); process with the client toward identifying therapeutic changes.

36. Facilitate development of a plan for the client to change his/her living situation to foster recovery; revisit routinely and facilitate toward accomplishing a positive change in living situation.

22. Identify the positive impact that sobriety and freedom from self-harm will have on intimate and family relationships. (37)

23. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse and self-harm. (38, 39)

24. Learn and implement personal coping strategies to manage urges to lapse back into chemical use. (40)

25. Identify, challenge, and replace destructive self-talk with positive, strength-building self-talk. (41, 42)

37. Assist the client in identifying positive changes that will result in family relationships due to sobriety and working a plan for recovery.

38. Discuss the negative effects the client's substance abuse and self-harm has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.

39. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends later or if working Steps 8 and 9 of an AA program (see *The Alcoholism & Drug Abuse Client Workbook* by Perkinson).

40. Teach the client tailored coping strategies involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., distraction from urges, staying focused on behavioral goals of abstinence) to manage triggered urges to use chemical substances.

41. Use cognitive therapy approaches to explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.

42. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Journal and Replace

Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success.

26. Participate in gradual repeated exposure to triggers of urges to lapse back into chemical substance use and self-harm within individual or group therapy sessions and between them; review with group members and therapist. (43, 44)

43. Direct and assist the client in construction of a hierarchy of urge-producing cues to use substances (or assign "Self-Harm Risk Factors, Triggers and Early Warning Signs" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

44. Select initial in vivo or role-played cue exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure, review with the client and group members, if done in group.

27. Learn and implement personal skills to manage common day-to-day challenges and build confidence in managing them without the use of substances or self-harming behaviors. (45, 46)

45. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build social and/or communication skills to manage these challenges without the use of substances.

46. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

28. Implement relapse prevention strategies for managing possible future situations with high risk for relapse. (47, 48, 49, 50, 51)

29. Verbalize that there are options to substance use and self-harm in dealing with stress and in finding pleasure or excitement in life. (52, 53, 54)

47. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

48. Using a 12-step recovery program's relapse prevention exercise, help the client uncover his/her triggers for relapse (see *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

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

50. Request that the client identify feelings, behaviors, and situations that place him/her at a higher risk for substance abuse (or assign "Relapse Triggers" in the *Adult Psychotherapy Homework Planner* by Jongsma).

51. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner* by Jongsma).

52. Teach the client the importance of getting pleasure out of life without using mood-altering substances.

53. Assist the client in developing a list of pleasurable activities (or assign "Identify and Schedule Pleasant Activities" in the *Adult*

Psychotherapy Homework Planner by Jongsma); assign engagement in selected activities daily.

54. Encourage the client to establish a daily routine of physical exercise to build body stamina, self-esteem, and reduce depression (see *Exercising Your Way to Better Mental Health* by Leith).

30. Complete a survey to assess the degree of satisfaction with treatment. (55)

55. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	305.00	Alcohol Abuse
	305.60	Cocaine Abuse
	305.30	Hallucinogen Abuse
	305.90	Inhalant Abuse
	305.50	Opioid Abuse
	305.90	Phencyclidine Abuse
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
	303.90	Alcohol Dependence
	305.20	Cannabis Abuse
	305.70	Amphetamine Abuse
	304.40	Amphetamine Dependence
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.50	Hallucinogen Dependence
	304.60	Inhalant Dependence
	304.00	Opioid Dependence

	304.90	Phencyclidine Dependence
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	_____	_____
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Axis II:	301.83	Borderline Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
305.00	F10.10	Alcohol Use Disorder, Mild
305.70	F15.10	Amphetamine-Type Substance Use Disorder, Mild
305.20	F12.10	Cannabis Use Disorder, Mild
305.60	F14.10	Cocaine Use Disorder, Mild
305.30	F16.10	Other Hallucinogen Use Disorder, Mild
305.90	F18.10	Inhalant Use Disorder, Mild
305.50	F11.10	Opioid Use Disorder, Mild
305.90	F16.10	Phencyclidine Use Disorder, Mild
305.40	F13.10	Sedative, Hypnotic, Anxiolytic Use Disorder, Mild
03.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.70	F15.20	Amphetamine-Type Substance Use Disorder, Moderate or Severe
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
304.50	F16.20	Other Hallucinogen Use Disorder, Moderate or Severe
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
304.60	F16.20	Phencyclidine Use Disorder, Moderate or Severe
304.10	F13.20	Sedative, Hypnotic, Anxiolytic Use Disorder, Moderate or Severe
301.83	F60.3	Borderline Personality Disorder

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

SEXUAL ABUSE

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

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

5. Establish whether sexual abuse occurred.
6. Begin the process of moving away from being a victim of sexual abuse and toward becoming a survivor of sexual abuse who is in control.
7. Terminate the use of mood-altering chemicals to cope with the trauma of sexual abuse.

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SHORT-TERM OBJECTIVES

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

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

THERAPEUTIC INTERVENTIONS

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

an evidence-based intervention for the disorder (see, for example, "Posttraumatic Stress Disorder," "Unipolar Depression," or "Borderline Traits" chapters in this *Planner*).

3. Disclose any history of substance use that may contribute to and complicate the treatment of sexual abuse. (5)
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)
5. Perform a substance abuse evaluation and make the client's substance abuse a focus of treatment if warranted.
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).
5. Describe how sexual abuse has led to feelings of powerlessness and substance abuse. (10, 11)	10. Assist the client in listing ways in which sexual abuse contributed to his/her feelings of powerlessness, unmanageability, and addictive behaviors.
	11. Educate the client about sexual abuse and how mood-altering chemicals are used to deal with uncomfortable feelings.
6. Verbalize the role of a higher power in recovering from sexual abuse. (12, 13)	12. Assign the client to complete a Step 3 exercise and teach him/her how to use a higher power in dealing with sexual abuse issues.
	13. Ask the client to list five ways a higher power can assist in dealing with sexual abuse.
7. Identify a support system of key individuals who will be encouraging and helpful in aiding the process of resolving the issue. (14, 15)	14. Help the client identify those individuals who would be compassionate and encourage him/her to enlist their support (or assign "Internal and External Resources for Safety" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	15. Encourage the client to attend a support group for survivors of sexual abuse.

8. Verbalize an increased knowledge of sexual abuse and its effects. (16, 17)

16. Assign the client to read material on sexual abuse (e.g., *Getting Through the Day: Strategies for Adults Hurt as Children* by Napier; *Betrayal of Innocence* by Forward and Buck; *Outgrowing the Pain* by Gil; *Reclaiming Your Life After Rape: Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder–Client Workbook* by Rothbaum and Foa); process key concepts.

17. Assign and process a written exercise from *Healing the Trauma of Abuse: A Women's Workbook* by Copeland and Harris.

9. Identify and express the feelings connected to the abuse. (18, 19)

18. Explore, encourage, and support the client in verbally expressing and clarifying feelings associated with the abuse.

19. Encourage the client to be open in talking of the abuse without shame or embarrassment as if he/she were responsible for the abuse.

10. Decrease the secrecy in the family by informing key nonabusive members regarding the abuse. (20, 21, 22)

20. Guide the client in an empty chair conversation exercise with a key figure connected to the abuse (e.g., perpetrator, sibling, parent), telling him/her of the sexual abuse and its effects.

21. Hold a conjoint session where the client tells his/her spouse of the abuse.

22. Facilitate a family session with the client, assisting and supporting him/her in revealing the abuse to parent(s).

11. Describe how a sex abuse experience is part of a family pattern of broken boundaries. (23)

23. Develop with the client a genogram and assist in illuminating key family patterns of broken boundaries related to

	sex and intimacy through physical contact or verbal suggestiveness.
12. Verbalize the ways the sexual abuse has had an impact on life. (24, 25)	24. Ask the client to make a list of the ways sexual abuse has impacted his/her life including substance abuse; process the list content.
	25. Develop with the client a symptom line connected to the abuse.
13. Clarify memories of the abuse. (26, 27)	26. Refer or conduct hypnosis with the client to further uncover or clarify the nature and extent of the abuse.
	27. Facilitate the client's recall of the details of the abuse by asking him/her to keep a journal and talk and think about the incidents (or assign "Picturing the Place of the Abuse" or "Describe the Trauma" in the *Adult Psychotherapy Homework Planner* by Jongsma). Caution him/her against embellishment based on book, video, or drama material, and be very careful not to lead the client into only confirming therapist-held suspicions.
14. Decrease statements of shame, being responsible for the abuse, or being a victim, while increasing statements that reflect personal empowerment. (28, 29, 30, 31)	28. Assign the client to read material on overcoming shame (e.g., *Healing the Shame That Binds You* by Bradshaw; *Facing Shame* by Fossum and Mason); process key concepts.
	29. Encourage, support, and assist the client in identifying, expressing, and processing any feelings of guilt related to feelings of physical pleasure, emotional fulfillment, or responsibility connected with the

events; help the client compose a list of 10 reasons he/she is not responsible for the sexual abuse.

30. Confront and process with the client any statements that reflect taking responsibility for the abuse or indicating he/she is a victim; assist the client in feeling empowered by working through the issues and letting go of the abuse (or assign "It Wasn't My Fault" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

31. Assign the client to complete a cost-benefit exercise (see *Ten Days to Self- Esteem* by Burns), or a similar exercise on being a victim versus a survivor or on holding on versus forgiving; process completed exercises.

15. Identify the positive benefits for self of being able to forgive all those involved with the abuse. (32, 33, 34)

32. Read and process the story from *Stories for the Third Ear* by Wallas entitled "The Seedling" (a story for a client who has been abused as a child).

33. Assist the client in removing any barriers that prevent him/her from being able to identify the benefits of forgiving those responsible for the abuse.

34. Recommend that the client read *Forgive and Forget* by Smedes; process the content of the book after the reading is completed.

16. Express feelings to and about the perpetrator, including the impact the abuse has had both at the time of occurrence and currently. (35, 36, 37)

35. Assign the client to write an angry letter to the perpetrator of the sexual abuse; process the letter within the session.

36. Prepare the client for a face-to-face meeting with the perpetrator

	of the abuse by processing the feelings that arise around the event and role-playing the meeting.
	37. Hold a conjoint session where the client confronts the perpetrator of the abuse; afterward, process his/her feelings and thoughts related to the experience.
17. Increase level of forgiveness of self, perpetrator, and others connected with the abuse. (38)	38. Assign the client to write a forgiveness letter and/or complete a forgiveness exercise (or assign "A Blaming Letter and a Forgiving Letter to Perpetrator" in the *Adult Psychotherapy Homework Planner* by Jongsma); process each with therapist.
18. Increase level of trust of others as shown by more socialization and greater intimacy tolerance. (39, 40)	39. Teach the client the share-check method of building trust in relationships (i.e., share only a little of self and then check to be sure that the shared data is treated respectfully, kindly, and confidentially; as proof of trustworthiness is verified, share more freely).
	40. Use role-playing and modeling to teach the client how to establish reasonable personal boundaries that are neither too porous nor too restrictive.
19. Verbally identify self as a survivor of sexual abuse. (41, 42)	41. Reinforce with the client the benefits of seeing himself/herself as a survivor rather than the victim and work to remove any barriers that remain in the way of him/her doing so (or assign "Changing from Victim to Survivor" in the *Adult Psychotherapy Homework Planner* by Jongsma).

42. Give positive verbal reinforcement when the client identifies himself/herself as a survivor.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.90	Alcohol Dependence
	304.80	Polysubstance Dependence
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.02	Generalized Anxiety Disorder
	300.14	Dissociative Identity Disorder
	300.15	Dissociative Disorder NOS
	995.53	Sexual Abuse of Child, Victim
	995.83	Sexual Abuse of Adult, Victim
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.02	F41.1	Generalized Anxiety Disorder
300.14	F44.81	Dissociative Identity Disorder

300.15	F44.9	Unspecified Dissociative Disorder
300.15	F44.89	Other Specified Dissociative Disorder
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter
301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder

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

SEXUAL PROMISCUITY

BEHAVIORAL DEFINITIONS

1. Engages in repeated acts of sexual intimacy with partner with whom there is no meaningful emotional or lasting social relationship.
2. Reports a preoccupation with sexual thoughts, actions, and deeds.
3. Has a history of sexually acting out that is potentially self-damaging (e.g., unprotected sex, hiring prostitutes, cruising the streets for sex, many different sexual partners).
4. Demonstrates a pattern of sexual behavior that seeks immediate gratification.
5. Engages in prostitution.
6. Lacks control over self-destructive sexual behavior.
7. Uses sexual behavior to cope or escape from stress or to reduce tension.
8. Overreacts to mildly sexually oriented stimulation.
9. Reports a sense of tension or affective arousal before engaging in sexual behavior and a reduction of tension after completing the sexual act.
10. Engages in illegal sexual acts with a minor.
11. Concomitant substance abuse accompanies the impulsive, emotionally detached sexual encounters.
12. Chemical dependence leads to an exchange of sex for mood-altering drugs.

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LONG-TERM GOALS

1. Maintain a program of recovery that is free from sexual promiscuity and addictive behavior.
2. Reduce the frequency of sexual promiscuity, and increase the frequency of meaningful sexual behavior.
3. Reduce thoughts that trigger sexual promiscuity, and increase self-talk that controls behavior.
4. Learn to stop, think, and plan before acting.
5. Learn stress reduction techniques to manage stress without the use of sexually promiscuous behavior.
6. Terminate substance abuse that accompanies sexual promiscuity.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize an understanding of the powerlessness and unmanageability that result from sexual promiscuity and addiction. (1)	1. Help the client to understand how sexual promiscuity and addiction lead to powerlessness and unmanageability (or assign the client to complete the Step 1 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
2. Describe the history and nature of the sexual promiscuity. (2)	2. Explore the client's history and nature of sexual promiscuity (or assign the "Looking Closer at My Sexual Behavior" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
3. Complete psychological testing or objective questionnaires for assessing sexual promiscuity. (3)	3. Administer to the client psychological instruments designed to objectively assess sexual promiscuity

(e.g., Derogatis Interview for Sexual Functioning, Multiphasic Sex Inventory—II, Sexual Adjustment Inventory); give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)

4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

	7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Identify the negative consequences of sexual promiscuity and addiction. (8, 9)	8. Assist the client in making connections between his/her sexual promiscuity and the negative consequences that he/she has experienced.
	9. Assign the client to write a list of the negative consequences that occurred because of his/her sexual promiscuity and addiction (or assign the "Connecting Sexual Behavior With Needs" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
6. Identify various times when sexual promiscuity led to addictive behavior. (10)	10. Explore times when the client acted too quickly on impulses, resulting in sexually promiscuous and addictive behavior (or assign the "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).
7. Verbalize how sexual promiscuity and addictive behavior meet the 12-step recovery program's criteria for *insanity*. (11)	11. Help the client to see that doing the same things over and over again and expecting different results meets the 12-step recovery program's definition

of *insanity* (or assign the client to complete the Step 2 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).

8. Increase the frequency of reviewing behavioral decisions with a trusted friend or family member for feedback regarding the consequences before the decision is enacted. (12)

9. Identify the biopsychosocial elements that have contributed to sexual promiscuity. (13)

10. Comply with a physician's evaluation regarding the necessity for psychopharmacological intervention, and take all medications as prescribed. (14, 15)

11. Identify and replace thoughts that trigger impulsive sexual behavior. (16, 17)

12. Conduct a session with the spouse, significant other, sponsor, or family member and the client to develop a contract for the client receiving feedback prior to engaging in sexually promiscuous acts.

13. Probe the client's biopsychosocial history and help him/her to see the possible causes for his/her sexual promiscuity such as family patterns of promiscuity, low self-esteem, sexual abuse, or mental illness (or assign "Is It Romance or Is It Fear?" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

14. Refer the client to a physician for an examination, to order medication as indicated, titrate medications, and monitor for side effects.

15. Monitor for effectiveness and side effects when the client takes prescribed medications.

16. Help the client to uncover dysfunctional thoughts that lead to sexual promiscuity; teach him/her to replace each one with an accurate, positive, self-enhancing, and adaptive thought (or assign "Working Through Shame" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

17. Help the client to develop a list of positive, accurate, and self-enhancing thoughts to read to

himself/herself each day, particularly when feeling tense or disparaged (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

12. Implement adaptive stress reduction techniques. (18, 19)

18. Use modeling, role-playing, and behavior rehearsal to teach the client adaptive stress-reduction techniques (e.g., talking to someone about the problem, taking a time-out, calling the sponsor, going to a meeting, engaging in exercise, practicing relaxation).

19. Teach the client relaxation techniques (e.g., progressive relaxation, self-hypnosis, biofeedback); assign him/her to relax whenever feeling tense or anxious (or assign "Self-Soothing: Calm Down, Slow Down" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

13. Implement the assertive formula, "I feel ____ when you ____; I would prefer it if ____" (20, 21)

20. Using modeling, role-playing, and behavior rehearsal, teach the client how to use the assertive formula, "I feel _____when you _____; I would prefer it if _____" in conflict situations.

21. Review implementation of assertiveness, feelings about it, as well as the consequences of it (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma); redirect as necessary.

14. Implement stopping, thinking, and planning before acting. (22, 23)

22. Using modeling, role-playing, and behavior rehearsal, teach the client how to use "stop, think, and plan before acting" in various current situations.

	23. Review the client's use of "stop, think, and plan before acting" in day-to-day living, and identify the positive consequences; redirect as necessary.
15. Verbalize an understanding of a 12-step program's Step 3 regarding the role of a higher power and how this step can be used in recovery from sexual promiscuity and addiction. (24)	24. Teach the client how to turn his/her will and life over to the care of a higher power; discuss how this step can be beneficial in recovery from sexual promiscuity and addictive behavior (e.g., understanding God's forgiveness and grace, practicing regular prayer, turning cravings over to God).
16. Write an autobiography detailing the exact nature of wrongs that were committed, and relate each of these wrongs to sexual promiscuity. (25)	25. Assign the client to write an autobiography of the exact nature of his/her wrongs, and to relate these wrongs to sexual promiscuity and addiction.
17. Disclose any history of sexual abuse in childhood, and relate that experience to current patterns of sexual behavior. (26, 27)	26. Explore the client's history of sexual abuse. 27. Relate the client's childhood sexual abuse to his/her current pattern of sexual promiscuity; refer the client for ongoing counseling that is focused on overcoming the effects of the sexual abuse.
18. Verbalize why a meaningful relationship is necessary for true sexual intimacy. (28)	28. Teach the client the importance of a meaningful relationship, to allow for true intimacy in a sexual encounter.
19. Identify those factors that contribute to difficulty with establishing intimate, trusting relationships. (29)	29. Explore the client's history of rejection or neglect, which may have led to an inability to form and/or maintain trusting, close, intimate relationships.
20. Identify triggers to sexual promiscuity and coping behaviors for each trigger. (30, 31)	30. Assist the client in identifying thoughts and situations that trigger urges to act out sexually.

	31. Develop with the client adaptive behaviors to cope with trigger situations.
21. List personal advantages of monogamous sexual intimacy. (32)	32. Assist the client in identifying a list of personal advantages for him/her becoming monogamous in sexually intimate behavior (e.g., increased self-esteem, greater emotional intimacy, development of trust and respect from others, living within a spiritual value system, reduced health risk).
22. Develop and write out a continuing care program that includes the recovery group's meetings and any further therapy that is necessary for recovery. (33)	33. Help the client to develop an aftercare plan that includes attending recovery groups regularly, getting a sponsor, and any further therapy that is necessary to recover from sexual promiscuity and any other addictive behavior (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
23. Complete a survey to assess the degree of satisfaction with treatment. (34)	34. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	302.2	Pedophilia
	312.8	Conduct Disorder
	309.3	Adjustment Disorder With Disturbance of Conduct
	312.30	Impulse-Control Disorder NOS
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Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
302.2	F65.4	Pedophilic Disorder
312.8	F91.x	Conduct Disorder
309.3	F43.24	Adjustment Disorder With Disturbance of Conduct
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder

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

SLEEP DISTURBANCE

BEHAVIORAL DEFINITIONS

1. Complains of difficulty falling asleep
2. Complains of difficulty remaining asleep.
3. Chronically uses alcohol or drugs to sleep.
4. Often fearful about being able to sleep as night approaches.
5. Exhibits daytime sleepiness or falling asleep too easily during daytime.
6. Insomnia or hypersomnia complaints due to a reversal of the normal sleep–wake schedule.
7. Reports distress resulting from repeated awakening with detailed recall of extremely frightening dreams involving threats to self.
8. Experiences abrupt awakening with a panicky scream followed by intense anxiety and autonomic arousal, no detailed dream recall, and confusion or disorientation.
9. Others report repeated incidents of sleepwalking accompanied by amnesia for the episode.

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LONG-TERM GOALS

1. Restore restful sleep pattern.
2. Feel refreshed and energetic during wakeful hours.
3. Terminate fear of sleeping poorly.
4. Understand the negative effects of mood-altering chemicals on sleep.

5. Discontinue using medications for sleep.
6. Terminate anxiety-producing dreams that cause awakening.
7. End abrupt awakening in terror and return to peaceful, restful sleep pattern.
8. Restore restful sleep with reduction of sleepwalking incidents.

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SHORT-TERM OBJECTIVES

1. Describe the history and details of sleep pattern. (1, 2)

2. Share history of substance abuse or medication use and the relationship to sleep disturbance. (3)

THERAPEUTIC INTERVENTIONS

1. Assess the client's sleep history including sleep pattern, bedtime routine, activities associated with the bed, activity level while awake, nutritional habits including stimulant use, napping practice, actual sleep time, rhythm of time for being awake versus sleeping, and so on.

2. Assign the client to keep a journal of sleep patterns, stressors, thoughts, feelings, and activities associated with going to bed, and other relevant client-specific factors possibly associated with sleep problems (or assign "Assessing Sleep Problems" in the *Addiction Treatment Homework Planner* by Finley and Lenz); process the material for details of the sleep–wake cycle.

3. Assess the contribution of the client's medication or substance abuse to his/her sleep disorder; note whether sleep problems

	predate the client's substance abuse or vice versa.
3. Verbalize depressive or anxious feelings and share possible causes. (4)	4. Assess the role of depression or anxiety as the cause of the client's sleep disturbance (see the "Unipolar Depression" or "Anxiety" chapters in this *Planner*).
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)	5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
	6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
	7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

		8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
	5. Verbalize an understanding of the relationship between sleep disturbance and substance use. (9, 10)	9. Educate the client about how regular use of mood-altering chemicals for sleep can increase sleep problems.
		10. Teach the client how sleep problems can lead to substance abuse and substance abuse can lead to sleep problems.
EBT	6. Keep physician appointment to assess possible medical contributions to sleep disorder and the need for psychotropic medications. (11)	11. Refer the client to a physician to rule out medical or pharmacological causes for sleep disturbance and to consider sleep lab studies and/or need for a prescription of psychotropic medications; exercise extreme caution in providing a substance using client with addicting medications. EBT
EBT	7. Take psychotropic medication as prescribed to assess the effect on sleep. (12)	12. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects; be alert for abuse of prescription medication. EBT
EBT	8. Verbalize an understanding of normal sleep, sleep disturbances, and their treatment. (13, 14, 15)	13. Provide the client with basic sleep education (e.g., normal length of sleep, normal

variations of sleep, normal time to fall asleep, and normal midnight awakening (recommend *The Insomnia Workbook: A Comprehensive Guide to Getting the Sleep You Need* by Silberman); help the client understand the exact nature of his/her abnormal sleeping pattern.

14. Provide the client with a rationale for the therapy, explaining the role of cognitive, emotional, physiological, and behavioral contributions to good and poor sleep.

15. Ask the client to read material consistent with the therapeutic approach to facilitate his/her progress through therapy (e.g., *Say Good Night to Insomnia* by Jacobs; *The Harvard Medical School Guide to a Good Night's Sleep* by Epstein and Mardon).

9. Learn and implement calming skills for use at bedtime. (16, 17)

16. Teach the client calming skills such as progressive muscle relaxation, guided imagery, slow diaphragmatic breathing, meditation, and mindfulness (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); teach the client how to apply these skills to facilitate relaxation and sleep at bedtime (see *No More Sleepless Nights* by Hauri, Jarman, and Linde); consider assigning "Self-Soothing: Stay Calm, Slow Down" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

17. Refer the client for or conduct biofeedback training to strengthen the client's successful relaxation response.

10. Practice good sleep hygiene. (18)

18. Instruct the client in sleep hygiene practices such as restricting excessive liquid intake, spicy late night snacks, or heavy evening meals; exercising regularly, but not within 3–4 hours of bedtime; minimizing or avoiding caffeine, alcohol, tobacco, and stimulant intake (or assign "Improving Sleep Hygiene" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

11. Learn and implement stimulus control strategies to establish a consistent sleep–wake rhythm. (19, 20, 21, 22)

19. Discuss with the client the rationale for stimulus control strategies to establish a consistent sleep–wake cycle (see *Behavioral Treatments for Sleep Disorders* by Perlis, Aloia, and Kuhn).

20. Teach the client stimulus control techniques (e.g., lie down to sleep only when sleepy; do not use the bed for activities like watching television, reading, listening to music, but only for sleep or sexual activity; get out of bed if sleep doesn't arrive soon after retiring; lie back down when sleepy; set alarm to the same wake-up time every morning regardless of sleep time or quality; do not nap during the day); assign consistent implementation.

21. Instruct the client to move activities associated with arousal and activation from the bedtime ritual to other times during the

day (e.g., reading stimulating content, reviewing day's events, planning for next day, watching disturbing television).

22. Monitor the client's sleep patterns and compliance with stimulus control instructions; problem-solve obstacles and reinforce successful, consistent implementation.

12. Learn and implement a sleep restriction method to increase sleep efficiency. (23)

23. Use a sleep restriction therapy approach in which the amount of time in bed is reduced to match the amount of time the patient typically sleeps (e.g., from 8 hours to 5), thus inducing systematic sleep deprivation; periodically adjust sleep time upward until an optimal sleep duration is reached.

13. Identify, challenge, and replace self-talk contributing to sleep disturbance with positive, realistic, and reassuring self-talk. (24, 25)

24. Explore the client's schema and self-talk that mediate his/her emotional responses counter-productive to sleep (e.g., fears, worries of sleeplessness), challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase the likelihood of establishing a sound sleep pattern (see *Insomnia: A Clinical Guide to Assessment and Treatment* by Morin and Espie).

25. Assign the client a homework exercise in which he/she identifies targeted self-talk and creates reality-based alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing

corrective feedback toward improvement.

14. Implement a paradoxical instruction to stay awake as a means to counter anxiety interfering with sleep onset. (26)

26. Assign a paradoxical intervention in which the client tries to stay awake for as long as possible to diminish performance anxiety interfering with sleep; review implementation, reinforcing success; problem-solve obstacles.

15. Learn and implement skills for managing stresses contributing to the sleep problem. (27)

27. Use cognitive behavioral skills training techniques (e.g., instruction, covert modeling [i.e., imagining the successful use of the strategies], role-play, practice, and generalization training) to teach the client tailored skills (e.g., calming and coping skills, conflict resolution, problem-solving) for managing stressors related to the sleep disturbance (e.g., interpersonal conflicts that carry over and cause nighttime wakefulness); routinely review, reinforce successes, problem-solve obstacles toward effective everyday use (see *Insomnia: A Clinical Guide to Assessment and Treatment* by Morin and Espie; *Treating Sleep Disorders* by Perlis and Lichstein).

16. Verbalize an understanding of the cognitive behavioral approach to treating sleeplessness. (28, 29)

28. Assign the client to read material on the cognitive-behavioral treatment approach to sleeplessness (e.g., *Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach Workbook* by Edinger and Carney; *Say Good Night to Insomnia* by Jacobs).

29. Teach the client the thought-stopping technique to block negative self-defeating thinking that interferes with sleep (or

assign "Making Use of the Thought-Stopping Technique" in *Adult Psychotherapy Homework Planner* by Jongsma); monitor its use and effectiveness.

17. Participate in a scheduled awakening procedure to reduce the frequency of night wakening. (30)

30. Use a scheduled awakening procedure in which the client is gently and only slightly awakened 30 minutes prior to the typical time of the first night wakening, sleep terror, or sleepwalking incident; phase out the awakening as sleep terrors decrease (see *The Insomnia Workbook: A Comprehensive Guide to Getting the Sleep You Need* by Silberman).

18. Learn and implement relapse prevention practices. (31, 32, 33, 34, 35)

31. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an occasional and reversible slip into old habits and relapse with the decision to return to old habits that risk sleep disturbance (e.g., poor sleep hygiene, poor stimulus control practices).

32. Identify and rehearse with the client the management of future lapses.

33. Instruct the client to routinely use strategies learned in therapy (e.g., good sleep hygiene and stimulus control) to prevent relapse into habits associated with sleep disturbance.

34. Develop a coping card or other reminder where relapse prevention practices are recorded for the client's later use.

35. Schedule periodic maintenance sessions to help the client maintain therapeutic gains.

19. Discuss experiences of emotional traumas that may disturb sleep. (36)
20. Discuss fears regarding relinquishing control. (37)
21. Disclose fears of death that may contribute to sleep disturbance. (38)
22. Share childhood traumatic experiences associated with sleep experience. (39, 40)
23. Reveal sexual abuse incidents that continue to be disturbing. (41)
24. Complete a survey to assess the degree of satisfaction with treatment. (42)

36. Explore recent traumatic events that may be interfering with the client's sleep.
37. Probe the client's fears related to letting go of control; seek to resolve those fears resulting in better sleep.
38. Probe a fear of death that may contribute to the client's sleep disturbance; use cognitive restructuring to replace negative messages with alternative healthy thoughts.
39. Explore traumas of the client's childhood that surround the sleep experience (see the "Childhood Trauma" chapter in this *Planner*).
40. Probe the client for the presence and nature of disturbing dreams and explore their possible relationship to present or past trauma.
41. Explore for possible sexual abuse to the client that has not been revealed (see the "Sexual Abuse" chapter in this *Planner*).
42. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.42	Primary Insomnia
	307.44	Primary Hypersomnia
	307.45	Circadian Rhythm Sleep Disorder
	307.47	Nightmare Disorder
	307.46	Sleep Terror Disorder
	307.46	Sleepwalking Disorder
	309.81	Posttraumatic Stress Disorder
	296.xx	Major Depressive Disorder
	300.4	Dysthymic Disorder
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.42	G47.00	Insomnia
307.44	G47.10	Hypersomnolence Disorder
307.45	G47.xx	Circadian Rhythm Sleep–Wake Disorder
307.47	F51.5	Nightmare Disorder
307.46	F51.4	Non-Rapid Eye Movement Sleep Arousal Disorder, Sleep Terror Type
307.46	F51.3	Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking Type
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder

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

SOCIAL ANXIETY*

BEHAVIORAL DEFINITIONS

1. Overall pattern of social anxiety, shyness, or timidity that presents itself in most social situations.
2. Hypersensitivity to the criticism or disapproval of others.
3. No close friends or confidants outside of first-degree relatives.
4. Avoidance of situations that require a degree of interpersonal contact.
5. Reluctant involvement in social situations out of fear of saying or doing something foolish or of becoming emotional in front of others.
6. Debilitating performance anxiety and/or avoidance of required social performance demands.
7. Increased heart rate, sweating, dry mouth, muscle tension, and shakiness in social situations.
8. Acknowledges never having learned social skills that would decrease anxiety and increase confidence.
9. Uses addictive behavior in an attempt to control anxiety symptoms.
10. Lacks the necessary social skills to initiate and maintain relationships.

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* Much of the content of this chapter (with minor revisions) is taken from *The Complete Adult Psychotherapy Treatment Planner*, 5th ed., by A. E. Jongsma, Jr., L. M. Peterson, and T. J. Bruce, 2014, Hoboken, NJ: Wiley. Copyright © 2014 by A. E. Jongsma, Jr., L. M. Peterson, and T. J. Bruce. Reprinted with permission.

LONG-TERM GOALS

1. Interact socially without excessive anxiety.
2. Participate in social performance requirements without undue fear or anxiety.
3. Develop the social skills that are necessary to reduce excessive anxiety in social situations, and terminate reliance on addiction as a coping mechanism.
4. Maintain a program of recovery that is free from excessive social anxiety and addiction.
5. Decrease thoughts that trigger anxiety, and increase positive, self-enhancing self-talk.
6. Learn the relationship between anxiety and addiction.
7. Form relationships that will enhance a recovery support system.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history and nature of social fears and avoidance. (1, 2)	1. Establish rapport with the client toward building a therapeutic alliance. 2. Assess the client's history of social anxiety and avoidance including frequency, intensity, and duration of anxiety symptoms, triggers, and the nature and extent of avoidance (e.g., The Anxiety Disorders Interview Schedule–Adult Version).
2. Complete psychological testing or objective questionnaires for assessing social anxiety and social skills. (3)	3. Administer a measure of social anxiety to further assess the depth and breadth of social fears and avoidance (e.g., The

Liebowitz Social Anxiety Scale; Social Interaction Anxiety Scale; Social Phobia Inventory); give feedback to the client; readminister as needed to assess treatment progress.

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)

4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine

	appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Acknowledge the powerlessness and unmanageability that are caused by excessive social anxiety and addiction. (8, 9, 10)	8. Help the client to see how social anxiety and powerlessness over addiction have made his/her life unmanageable.
	9. Teach the client about the relationship between social anxiety and addiction (i.e., how the substance was used to treat the anxious symptoms, and why more substance use became necessary) (or assign "Action Plan to Address Social Anxiety" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	10. Teach the client about the 12-step program concept of *insanity*, and help him/her to see how engaging in the same ineffective, self-defeating, and dysfunctional patterns of behavior in an attempt to overcome social anxiety and addiction is insane.
5. Cooperate with an evaluation by a physician for psychotropic medication. (11)	11. Arrange for the client to have an evaluation by a physician for a prescription of psychotropic medications.
6. Take prescribed psychotropic medications consistently. (12)	12. Monitor the client for prescription compliance, side

	effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. EBP
7. Participate in a small group therapy for social anxiety. (13)	13. Enroll client in a small (closed enrollment) cognitive-behavioral group therapy for social anxiety (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; the "Shyness" chapter in *The Group Therapy Treatment Planner* by Paleg and Jongsma; *Social Anxiety Disorder* by Turk, Heimberg, and Hope). EBP
EBP 8. Verbalize an accurate understanding of the vicious cycle of social anxiety and avoidance. (14, 15)	14. Discuss how social anxiety derives from cognitive biases that overestimate negative evaluation by others, undervalue the self, distress, and often lead to unnecessary avoidance. EBP
	15. Assign the client to read psychoeducational chapters of books or treatment manuals on social anxiety that explain the cycle of social anxiety and avoidance and the rationale for cognitive behavioral treatment (e.g., *Overcoming Social Anxiety and Shyness* by Butler; *The Shyness and Social Anxiety Workbook* by Antony and Swinson; *Managing Social Anxiety* by Hope, Heimberg, and Turk). EBP
EBP 9. Verbalize an understanding of the rationale for cognitive behavioral treatment of social anxiety. (16)	16. Discuss how therapy based on cognitive behavioral principles targets fear and avoidance to desensitize learned fear, build social skills, reality-test anxious thoughts, and increase confidence and social effectiveness. EBP

10. Keep a daily journal of social anxiety rating, including the situations that cause anxious feelings and the negative thoughts that fueled social anxiety. (17)

11. Learn and implement calming and coping strategies to manage anxiety symptoms during moments of social anxiety and lead to a more relaxed state in general. (18)

12. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (19, 20)

17. Assign the client to keep a daily record of social anxiety, including a description of each situation that caused anxious feelings, the rating of anxiety, using Subjective Units of Distress (SUDs), and thoughts that triggered the anxiety; process the journal material; help the client uncover the dysfunctional, distorted thoughts that fueled the social anxiety.

18. Teach and ask the client to practice relaxation and attentional focusing skills (e.g., staying focused externally and on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, ride the wave of anxiety) for managing social anxiety symptoms and maintaining a more relaxed approach to life (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review, reinforce successes; provide corrective feedback toward effective use.

19. Explore the client's self-talk and underlying beliefs that mediate his/her social fears, challenge the biases (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); assist him/her in generating appraisals that correct for the biases and build confidence.

20. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; test

fear-based predictions against alternatives using behavioral experiments; review; reinforce success, problem-solve obstacles toward accomplishing objective (see "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma; *The Shyness and Social Anxiety Workbook* by Antony and Swinson).

13. Participate in gradual repeated exposure to feared social situations within and outside of therapy. (21, 22, 23)

21. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response.

22. Select initial in vivo or role-played exposures that have a high likelihood of being a successful experience for the client; do cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate progress through the hierarchy (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; *Managing Social Anxiety* by Hope, Heimberg, and Turk).

23. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (or assign "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma; also see *The Shyness and Social Anxiety Workbook* by Antony and Swinson); review and reinforce success, providing corrective feedback toward improvement.

14. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (24, 25)

24. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; *Managing Social Anxiety* by Hope, Heimberg, and Turk).

25. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

15. Implement relapse prevention strategies for managing possible future anxiety symptoms. (26, 27, 28, 29)

26. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

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

28. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships.

29. Develop a coping card on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," and "It will go away") are recorded for the client's later use.

16. Participate in Acceptance and Commitment Therapy (ACT) for panic disorder. (30, 31, 32, 33)

17. Identify important people in life, past and present, and describe the quality, good and poor, of those relationships. (34)

30. Use an ACT approach to help the client accept and openly experience anxious thoughts and feelings without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

31. Teach mindfulness meditation to help the client recognize the negative thought processes associated with social anxiety and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing but not reacting to non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [audio CD] by Zabat-Zinn).

32. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

33. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert; *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy* by Hayes).

34. Conduct Interpersonal Therapy (apply *Comprehensive Guide to Interpersonal Psychotherapy* by Weissman, Markowitz, and

Klerman), beginning with the assessment of the client's interpersonal inventory of important past and present relationships; develop a case formulation linking social anxiety grief, interpersonal role disputes, role transitions, and/or interpersonal deficits.

18. Verbalize and demonstrate an understanding and resolution of current interpersonal problems. (35, 36, 37, 38)

35. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.

36. For interpersonal disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

37. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role.

38. For interpersonal deficits, help the client develop new interpersonal skills and relationships.

19. Explore past experiences that may be the source of low self-esteem and social anxiety currently. (39, 40)

39. Probe childhood experiences of criticism, abandonment, or abuse that would foster low self-esteem and shame process these.

40. Assign the client to read books on resolving feelings of shame (e.g., *Healing the Shame That Binds You* by Bradshaw and *Facing Shame* by Fossum and Mason); process key ideas.

20. Work through developmental conflicts that may be influencing current struggles with fear and avoidance and take appropriate actions. (41)

41. Use an insight-oriented approach to explore how psychodynamic conflicts (e.g., separation/autonomy; anger recognition, management, and coping) may be manifesting as social fear and avoidance; address transference; work through separation and anger themes during therapy and upon termination toward developing a new ability to manage separations and autonomy.

21. Report on instances when worries and anxieties were turned over to a higher power. (42, 43, 44)

42. Teach the client the benefits of turning his/her will and life over to the care of a higher power of his/her own understanding.

43. Using a Step 3 exercise from a 12-step recovery program, teach the client how to turn problems, worries, and anxieties over to a higher power and trust that the higher power is going to help him/her resolve the situation.

44. Review and reinforce the client's implementation of turning social anxiety over to a higher power.

22. Verbally report positive outcomes of participation in social and support groups. (45, 46, 47)

45. Ask the client to attend and participate in available social and recreational activities within the treatment program and/or the community (or assign "Using My Support Network" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

	46. Refer the client to a self-help group (i.e., Alcoholics Anonymous, Narcotics Anonymous, Emotions Anonymous, Recovery) and to self-disclose twice in each session; process the experience.
	47. Monitor, encourage, redirect, and give positive feedback to the client as he/she increases his/her interaction with others.
23. Complete a survey to assess the degree of satisfaction with treatment. (48)	48. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.23	Social Phobia
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.7	Body Dysmorphic Disorder
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.0	Paranoid Personality Disorder
	310.22	Schizotypal Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.7	F45.22	Body Dysmorphic Disorder
301.82	F60.6	Avoidant Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
310.22	F21	Schizotypal Personality Disorder
301.20	F60.1	Schizoid Personality Disorder

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

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

SPIRITUAL CONFUSION

BEHAVIORAL DEFINITIONS

1. Verbalizes confusion about spiritual matters, leading to a negative attitude about using a higher power in recovery.
2. Upholds religious convictions that are negative toward addiction and toward a 12-step program of recovery.
3. Fears that God is angry with the client, preventing a connection with a higher power.
4. Refuses to seek conscious contact with God because of anger toward God.
5. Is actively involved in a religious system that is not supportive of a 12-step recovery program.
6. Lacks understanding of the need for a higher power.
7. Maintains spiritual beliefs that are negative toward the existence of a positive higher power.
8. Anger at God leads to a rejection of any religious system or personal spiritual development.

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LONG-TERM GOALS

1. Maintain a program of recovery, free of addiction and spiritual confusion.

2. Resolve spiritual conflicts, allowing for a meaningful relationship with a higher power.
3. Understand the relationship between spiritual confusion and addiction.
4. Accept that a higher power can assist in relieving addiction.
5. Develop a concept of a higher power that is loving and supportive to recovery.
6. Learn the difference between religion and spirituality.
7. Learn how to pray and meditate as a means of making conscious contact with the higher power.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the thoughts and feelings associated with the role of spirituality in personal life. (1)	1. Explore the client's spiritual journey, religious training, thoughts, and feelings toward a higher power, and current spiritual practices (or assign "My History of Spirituality" in the *Adult Psychotherapy Homework Planner* by Jongsma).
2. Complete psychological testing or objective questionnaires for assessing spiritual confusion. (2)	2. Administer to the client psychological instruments designed to objectively assess spiritual confusion (e.g., Spiritual Well-Being Scale); give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM*	3. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight

diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

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).

4. 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).
5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment

	but the presenting problem now is causing mild or moderate impairment).
4. Verbalize the powerlessness and unmanageability that result from spiritual confusion and addictive behavior. (7)	7. Help the client to accept that he/she is powerless over spiritual confusion and addictive behavior, and that his/her life is unmanageable (or assign the client to complete the Step 1 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
5. Verbalize an understanding of how spiritual confusion contributed to addictive behavior and how addiction led to spiritual confusion. (8, 9, 10)	8. Probe the client's history of spiritual confusion, and show him/her how this confusion contributed to addiction and a negative attitude toward recovery. 9. Help the client to identify how addiction led to spiritual confusion. 10. Help the client understand how his/her spiritual confusion and addictive behavior can lead to a feeling of insanity if the same old approach is continually taken to recover from each (or assign the client to complete the Step 2 exercise in *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
6. Verbalize how spiritual confusion leads to a negative attitude toward working a 12-step program of recovery. (11)	11. Show the client how negative attitudes toward spiritual matters make recovery difficult when using a 12-step program that relies on a higher power.
7. Verbalize an understanding of the 12-step recovery program's concept of "God as we understand Him." (12)	12. Teach the client about the 12-step recovery program's concept of "God as we understand Him," and how this relates to his/her spiritual confusion (or assign "Understanding Spirituality" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

8. Verbalize how many different religions and cultures can work in a 12-step program of recovery. (13)

13. Teach the client how many different religions and cultures can implement a similar 12-step program of recovery.

9. Verbalize an understanding of a higher power's grace and willingness to forgive. (14, 15, 16)

14. Teach the client that his/her higher power should not be a basis for condemnation of him/her but provide a guide for living with hope and peace.

15. Assign the client to read books on the process of forgiveness (e.g., *Forgive and Forget* by Smedes).

16. Assign the client to read a book on grace (e.g., *Addiction and Grace: Love and Spirituality in the Healing of Addictions* by May; *Shame and Grace: Healing the Shame We Don't Deserve* by Smedes; or *Where in the World Is God? God's Presence in Every Moment of Our Lives* by Brizee); process key ideas.

10. List ways in which a higher power can assist in recovery from spiritual confusion and addiction. (17)

17. Teach the client about the importance of a higher power in a 12-step program, and list many ways that practicing faith can assist him/her (e.g., attend regular religious activities, speak weekly with a spiritual advisor, practice regular prayer and meditation).

11. Verbalize an understanding of the concept of God's plan. (18)

18. Assign the client to read page 417 in the Alcoholics Anonymous *Big Book*; then, teach him/her how everything that happens in the world is a part of God's good plan.

12. Verbalize the need to begin a spiritual journey, as outlined in the 12 steps. (19, 20, 21)

19. Arrange for the client to meet a clergyperson who is familiar with 12-step recovery programs, and encourage the client to share his/her thoughts and feelings

about a higher power (or assign "Finding a Higher Power That Makes Sense" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

20. Arrange for the client to meet with a contact person or temporary sponsor and discuss the 12-step recovery program, spiritual confusion, and addiction.

21. Assign the client to read "How It Works" in the Alcoholics Anonymous *Big Book* and to discuss the three pertinent ideas that are outlined at the end of the chapter: (1) "We were alcoholic and could not manage our own lives"; (2) "Probably no human power could have relieved our alcoholism"; and (3) "God could and would have if He were sought."

13. Make a written plan to continue a spiritual journey as outlined in the 12 steps. (22)

22. Using the 12 steps as a guide, help the client to make a written plan to continue his/her spiritual journey.

14. Write a letter to a higher power, sharing feelings and asking for specific needs in recovery. (23)

23. Assign the client to write a letter to a higher power, sharing how he/she thinks and feels and asking for what he/she wants to aid him/her in recovery; process the content of the letter.

15. Express a decision to turn own will and life over to a higher power, as it is understood. (24)

24. Teach the client how to turn problems over to a higher power rather than becoming anxious and depressed over them.

16. Practice prayer and meditation at least once a day. (25, 26, 27)

25. Assign the client to read Chapter 11 in Alcoholics Anonymous's *Twelve Steps and Twelve Traditions*; teach the client the importance of integrating his/her higher power into daily life.

	26. Assign the client to keep a journal, writing down his/her understanding of a higher power.
	27. Assign the client to write down each insight that he/she has gained from incorporating a higher power into his/her daily living and share these with the primary therapist.
17. Develop a written personal recovery plan. (28)	28. Help the client to develop a personal recovery plan that includes regular attendance at recovery groups, getting a sponsor, helping others in recovery, and any other treatment that is necessary to recover from spiritual confusion and addiction (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
18. Family members verbalize what each can do to assist the client in recovery. (29, 30)	29. Discuss with family members the connection between spiritual confusion and addictive behavior; outline the steps the client must take to successfully recover.
	30. In a family session, review what each member can do to assist the client in recovery.
19. Complete a survey to assess the degree of satisfaction with treatment. (31)	31. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	V62.89	Religious or Spiritual Problem
	V62.4	Acculturation Problem
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
V62.89	Z65.8	Religious or Spiritual Problem
V62.4	Z60.3	Acculturation Difficulty

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

SUBSTANCE-INDUCED DISORDERS

BEHAVIORAL DEFINITIONS

1. Experiences memory impairment (amnestic disorder) that persists beyond expected period of substance intoxication or withdrawal effects.
2. Experiences memory impairment and cognitive disturbance (dementia) that persist beyond expected period of substance intoxication or withdrawal effects.
3. Lacks clear awareness of the environment; is deficient in ability to focus attention; has memory dysfunction, language, and/or perceptual disturbance (delirium) that developed during or shortly after substance intoxication or withdrawal.
4. Experiences hallucinations or delusions that persist beyond expected period of substance intoxication or withdrawal effects.
5. Exhibits depressed mood that developed during or shortly after substance intoxication or withdrawal.
6. Exhibits markedly expansive mood that developed during or shortly after substance intoxication or withdrawal.
7. Reports prominent anxiety, panic attacks, or obsessions that developed during or shortly after substance intoxication or withdrawal.
8. Reports sleep disturbance that developed during or shortly after substance intoxication or withdrawal.
9. Presents with sexual dysfunction that developed during or shortly after substance intoxication or withdrawal.
10. Exhibits psychiatric signs and symptoms secondary to substance abuse or dependence.

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LONG-TERM GOALS

1. Learn the importance of working a 12-step program, and maintain a program of recovery from addiction and substance-induced disorders.
2. Restore normal sleep pattern, improve long- and short-term memory, and maintain abstinence from addiction.
3. Recover clear memory and an awareness of environment, realistic perceptions, coherent communication, focused attention, and abstain from addiction.
4. Reduce anxiety symptoms significantly, and abstain from addictive behavior.
5. Expansive mood returns to normal level, depressed mood is elevated to normal functioning, and abstinence from addiction is maintained.
6. Participate in medical management of substance-induced disorder and addiction.
7. Psychiatric signs and symptoms secondary to substance abuse return to normal levels.

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SHORT-TERM OBJECTIVES

1. Verbalize an understanding that the signs and symptoms of the substance-induced disorder are caused by chemical dependence. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Welcome the client to treatment and explain that he/she is in a safe place; encourage him/her to stay in treatment long enough to begin recovery.
2. Gather information regarding the client's recent substance abuse behavior and history of chemical dependence.
3. Teach the client about his/her substance-induced disorder and directly relate signs and

	symptoms to chemical abuse; indicate that the symptoms will ameliorate if the client remains abstinent.
2. Complete psychological testing or objective questionnaires for assessing substance-induced disorders. (4)	4. Administer to the client psychometric instruments designed to objectively assess substance-induced disorders (e.g., Beck Depression Inventory-II, Beck Anxiety Inventory, Clinical Institute Withdrawal Assessment of Alcohol Scale-Revised, Narcotic Withdrawal Scale, Mental Status Examination, Cognitive Capacity Screening Examination, etc.); give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.
3. Report to the staff any thoughts of causing harm to self or others. (5)	5. Assess the client's potential for harm to self or others, and take precautionary steps if needed; encourage reporting to the staff any future thoughts of causing harm to self or others.
4. Verbalize feelings that surround substance-induced disorder and addiction. (6)	6. Encourage the client to share the feelings that surround substance-induced disorder and addiction.
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. Submit to a physician's physical examination to assess bodily functions and the need for psychotropic medications. (11)

11. Refer the client to a physician to examine the client, write treatment orders as indicated, titrate medications, and monitor for effectiveness and side effects.

7. Take prescribed medications as directed by the physician, and report symptoms and side effects to the medical staff. (12)

12. Direct the staff to carry out orders as directed by the physician and to monitor the client's symptoms and the effectiveness and side effects of the prescribed medication.

8. Intake fluids and nourishment as indicated by the medical staff. (13)

13. Encourage the client to take fluids and nourishment as ordered by the physician.

9. Stay with a staff member during severe symptoms of substance-induced disorder, intoxication, or withdrawal. (14)

14. Assign a staff member to stay with the client during severe substance-induced disorder, intoxication, or withdrawal.

10. Reduce environmental stimulation to decrease excessive anxiety, perceptual disturbances, and irritability. (15)

15. Adjust the client's environment until there is minimal stimulation that might exacerbate excessive anxiety, perceptual disturbances, and irritability.

11. Talk with a treatment peer that is further along in the program, and discuss plans for recovery. (16)

16. Ask treatment peers to encourage the client during the early stages of recovery to stay the course and remain in treatment.

12. Verbalize the need for further treatment and develop a written plan to address substance-induced disorder and addiction. (17, 18)

17. Teach the client about 12-step recovery, and encourage him/her to stay in treatment; teach him/her about the different treatment support systems that are available in the community such as self-help groups like Alcoholics Anonymous, family support programs, spiritual programs, and vocational rehabilitation programs (or assign "Using My Support Network" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

18. Help the client develop a written plan to treat his/her substance-induced disorder and addiction (or assign "Exploring Treatment

and Recovery Options" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

13. Family members verbalize an understanding of the connection between substance-induced disorder and addiction. (19, 20)

19. In a family session, explain the connection between substance-induced disorder and addictive behavior.

20. Help the client to list three things that each family member can do to assist him/her in recovery.

14. Complete a survey to assess the degree of satisfaction with treatment. (21)

21. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	291.0	Alcohol Intoxication Delirium
	291.0	Alcohol Withdrawal Delirium
	291.2	Alcohol-Induced Persisting Dementia
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	291.5	Alcohol-Induced Psychotic Disorder With Delusions
	291.3	Alcohol-Induced Psychotic Disorder With Hallucinations
	291.89	Alcohol-Induced Mood Disorder
	291.89	Alcohol-Induced Anxiety Disorder
	291.8	Alcohol-Induced Sleep Disorder
	292.81	Other Substance Intoxication Delirium
	292.82	Other Substance-Induced Persisting Dementia

	292.xx	Other Substance-Induced Persisting Amnesia
	292.xx	Other Substance-Induced Psychotic Disorder
	292.84	Other Substance-Induced Mood Disorder
	292.89	Other Substance-Induced Anxiety Disorder
	292.89	Other Substance-Induced Sleep Disorder
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	_____	_____
Axis II:	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
291.0	F10.221	Alcohol Intoxication Delirium With Moderate or Severe Use Disorder
291.81	F10.231	Alcohol Withdrawal Delirium
291.2	F10.27	Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder
291.1	F10.26	Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder
291.9	F10.259	Alcohol-Induced Psychotic Disorder With Moderate or Severe Use Disorder
291.89	F10.24	Alcohol-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder
291.89	F10.282	Alcohol-Induced Anxiety Disorder With Moderate or Severe Alcohol Use Disorder
291.82	F10.280	Alcohol-Induced Sleep Disorder With Moderate or Severe Alcohol Use Disorder
292.81	F19.221	Other Substance Intoxication Delirium
292.82	F19.27	Other Substance-Induced Major Neurocognitive Disorder With Moderate or Severe Alcohol Use Disorder
292.9	F19.259	Other Substance-Induced Psychotic Disorder With Moderate or Severe Alcohol Use Disorder
292.84	F19.24	Other Substance-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder

292.89	F19.280	Other Substance-Induced Anxiety Disorder With Moderate or Severe Alcohol Use Disorder
292.85	F19.282	Other Substance-Induced Sleep Disorder With Moderate or Severe Alcohol Use Disorder

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

SUBSTANCE INTOXICATION/WITHDRAWAL

BEHAVIORAL DEFINITIONS

1. Demonstrates cognitive, behavioral, or emotional changes (e.g., alcohol on breath, belligerence, mood disorder, cognitive impairment, impaired judgment, slurred speech, ataxia) shortly after ingestion or exposure to a substance.
2. Presents with abnormal autonomic reactivity (e.g., elevated or decreased vital signs, tachycardia, dilated or constricted pupils, diaphoresis, flushed face) subsequent to the introduction of a mood-altering substance into the body.
3. Admits to recently abusing a mood-altering chemical.
4. Presents with urine, blood screen, or breathalyzer results that indicate recent substance use.
5. Exhibits psychological symptoms caused by substance withdrawal (e.g., irritability, anxiety, anger, emotional liability, depression, hallucinations, delusions).
6. Reports that intoxication or withdrawal symptoms cause significant impairment in work, school, or play.
7. Experiences a preoccupation with strong cravings, leaving treatment, and using mood-altering chemicals.

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LONG-TERM GOALS

1. Stabilize condition medically, behaviorally, emotionally, and cognitively, and return to functioning within normal parameters.
2. Recover from substance intoxication/withdrawal, and participate in a chemical dependency assessment.
3. Understand the severity of and reasons for the substance use, and enter a program of recovery.
4. Comply with assessments of substance intoxication and withdrawal.
5. Enter a program of recovery necessary to bring addiction under control.
6. Understand the extent of the danger to self and others when intoxicated.
7. Comply with all physician orders.
8. Keep medical staff informed of withdrawal symptoms.

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SHORT-TERM OBJECTIVES

1. Verbalize an acceptance of the need to be in a safe place to recover from substance intoxication/withdrawal. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing intoxication/withdrawal. (3)

THERAPEUTIC INTERVENTIONS

1. Welcome the client to the treatment setting; explain substance intoxication and the procedures that will be used to arrest symptoms.

2. Teach the client the importance of staying in treatment to recover from substance intoxication and possible withdrawal.

3. Administer to the client psychological instruments designed to objectively assess substance intoxication/withdrawal (e.g., Clinical Institute Withdrawal Assessment of Alcohol Scale-Revised, Clinical Opiate Withdrawal Scale, Narcotic Withdrawal

	Scale); give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.
3. Verbalize an agreement to cooperate with the medical management of substance intoxication/withdrawal. (4)	4. Inform the client of what he/she can expect during intoxication and withdrawal, and encourage him/her to cooperate with medical management; ask him/her to sign a consent-to-treat form.
4. Sign a release of information form to allow significant others to be informed about admission and condition. (5)	5. Encourage the client to sign a release of information form; contact significant others to gain support for the client's admission to treatment.
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 physician evaluation and take all medications as prescribed. (10)	10. Refer the client to a physician to examine him/her, educate about substance intoxication and withdrawal, order medications as appropriate, titrate medications, and monitor for effectiveness and side effects.
7. Report as to medication compliance, effectiveness, and side effects. (11, 12)	11. Direct the medical staff to carry out the orders of the physician and to administer medications as directed.
	12. Monitor the client's medications for compliance, effectiveness, and side effects.
8. Provide information for a biopsychosocial assessment of the extent of addiction/ dependence. (13)	13. Complete a biopsychosocial assessment to determine the extent of the client's addiction and the need for treatment.

9. Agree to stay with a staff member or treatment buddy during severe intoxication/withdrawal. (14)
10. Report any change in symptoms of intoxication/withdrawal to the medical staff. (15)
11. Blood work shows no presence of mood-altering substances. (16)
12. Vital signs stabilized within normal parameters. (17)
13. Demonstrate that cognitive, behavioral, and emotional functioning have returned to pre-intoxication status. (18)
14. Share the feelings that surround admission for substance intoxication/withdrawal. (19, 20, 21)
15. Sign a contract with the staff that the client will inform the staff if he/she has thoughts of causing harm to self or others. (22, 23)

14. Assign a staff member to remain with the client until he/she is through intoxication and withdrawal.
15. Teach the client what signs and symptoms he/she may experience during substance intoxication and/or withdrawal (or assign "Coping With Post-Acute Withdrawal" in the *Addiction Treatment Homework Planner* by Finley and Lenz); encourage him/her to report any significant change in symptoms to the medical staff.
16. Monitor the client's status via blood tests, and report findings in the clinical chart.
17. Monitor the client's vital signs and document the findings in his/her chart.
18. Evaluate the client's cognitive, behavioral, and emotional status as detoxification progresses, reporting the results on his/her chart.
19. Probe the client's feelings that surround his/her substance intoxication and admission for addiction treatment.
20. Teach the client that substance withdrawal means substance dependence; help him/her to make plans for treatment and recovery.
21. Share the results of a chemical dependence assessment, and discuss options for the treatment of addiction/dependence.
22. Assess danger to the client or others; encourage him/her to report any thoughts of causing harm to himself/herself or others.

	23. Help the client to reduce environmental stimulation to a level that will not exacerbate symptoms and not increase agitation.
16. Learn and cooperate with the rules of the treatment program. (24)	24. Teach the client the rules of the treatment program; encourage him/her to follow the rules while in treatment.
17. In a family session, discuss the connection between withdrawal symptoms and addiction. (25)	25. In a family session, discuss withdrawal symptoms and their connection with addiction.
18. Read letters of support from family members. (26)	26. Encourage the family members to write letters of support to the client; have him/her read the letters.
19. Complete a survey to assess the degree of client's satisfaction with treatment. (27)	27. Administer a survey to assess the client's degree of satisfaction with treatment.
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	303.00	Alcohol Intoxication
	292.89	Amphetamine Intoxication
	292.89	Cannabis Intoxication
	292.89	Cocaine Intoxication
	292.89	Hallucinogen Intoxication
	292.89	Opioid Intoxication
	292.89	Phencyclidine Intoxication
	292.89	Sedative, Hypnotic, or Anxiolytic Intoxication

291.81	Alcohol Withdrawal
292.0	Amphetamine Withdrawal
292.0	Cannabis Withdrawal
292.0	Cocaine Withdrawal
292.0	Opioid Withdrawal
292.0	Sedative, Hypnotic, or Anxiolytic Withdrawal
292.81	Other (or unknown) Substance Intoxication
292.0	Other (or unknown) Substance Withdrawal
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.00	F10.229	Alcohol Intoxication With Moderate or Severe Use Disorder
292.89	F15.222	Amphetamine Intoxication With Moderate or Severe Use Disorder
292.89	F12.222	Cannabis Intoxication With Moderate or Severe Use Disorder
292.89	F14.222	Cocaine Intoxication, With Perceptual Disturbances, With Moderate or Severe Use Disorder
292.89	F14.229	Cocaine Intoxication, Without Perceptual Disturbances, With Moderate or Severe Use Disorder
292.89	F11.222	Opioid Intoxication, With Perceptual Disturbances, With Moderate or Severe Use Disorder
292.89	F11.229	Opioid Intoxication, Without Perceptual Disturbances, With Moderate or Severe Use Disorder
292.89	F16.229	Phencyclidine Intoxication
292.89	F13.229	Sedative, Hypnotic, or Anxiolytic Intoxication With Moderate or Severe Use Disorder
291.81	F10.232	Alcohol Withdrawal With Perceptual Disturbances
291.81	F10.239	Alcohol Withdrawal Without Perceptual Disturbances
292.0	F15.23	Amphetamine Withdrawal
292.0	F12.288	Cannabis Withdrawal
292.0	F14.23	Cocaine Withdrawal
292.0	F11.23	Opioid Withdrawal

292.0	F13.231	Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
292.89	F19.229	Other Substance Intoxication With Moderate or Severe Use Disorder
292.81	F19.221	Other Substance Intoxication Delirium With Moderate or Severe Use Disorder
292.0	F19.239	Other Substance Withdrawal

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

SUBSTANCE USE DISORDERS

BEHAVIORAL DEFINITIONS

1. Demonstrates a maladaptive pattern of substance use, manifested by increased tolerance and withdrawal.
2. Fails to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Presents with blood work (e.g., elevated liver enzymes, electrolyte imbalance) and physical indicators (e.g., stomach pain, high blood pressure, malnutrition) that reflect the results of a pattern of heavy substance use.
4. Denies that chemical dependence is a problem, despite feedback from significant others that the use of the substance is negatively affecting him or her and others.
5. Experiences frequent blackouts when using.
6. Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance.
7. Demonstrates increased tolerance for the drug, as there is the need to use more to become intoxicated or to recall the desired effect.
8. Exhibits physical withdrawal symptoms (e.g., shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when going without the substance for any length of time.
9. Has a history of arrests for addiction-related offenses (e.g., driving under the influence [DUI], minor in possession [MIP], assault, possession/delivery of a controlled substance, shoplifting, breaking and entering [B&E]).
10. Reports suspension of important social, recreational, or occupational activities because they interfere with using.

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LONG-TERM GOALS

1. Accept the powerlessness and unmanageability over mood-altering substances, and participate in a recovery-based program.
2. Establish a sustained recovery, free from the use of all mood-altering substances.
3. Establish and maintain total abstinence, while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary 12-step skills to maintain long-term sobriety from all mood-altering substances, and live a life free of substance abuse.
5. Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals.
6. Utilize behavioral and cognitive coping skills to help maintain sobriety.

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SHORT-TERM OBJECTIVES

1. Provide honest and complete information for a chemical dependence biopsychosocial history. (1)

2. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (2)

THERAPEUTIC INTERVENTIONS

1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her use, signs and symptoms of use, and negative life consequences such as social, legal, familial, and vocational problems.

2. Administer to the client objective tests to assess substance use (e.g., Substance Use Disorders Diagnostic Schedule-IV,

	Substance Abuse Subtle Screen Inventory-3, the Addiction Severity Index, the Michigan Alcohol Screening Test); process the results with the client; readminister as needed to assess treatment response.
3. Participate in a medical evaluation to assess the effects of chemical dependence. (3)	3. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence (include tests for HIV, hepatitis, and sexually transmitted diseases).
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)	4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).
	5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with an evaluation by a physician for psychotropic medication. (8, 9)

8. Assess the need for psychotropic medication for any mental/emotional comorbidities, and discuss the use of acamprosate (Campral), naltrexone (Vivitrol), or disulfiram (Antabuse) where applicable to discourage chemical abuse and strengthen recovery; refer to a pharmacology-based treatment/recovery program (e.g., acamprosate, naltrexone), where applicable.
9. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.

6. Explore and resolve ambivalence associated with commitment to change behaviors related to substance use and addiction. (10, 11, 12, 13)

10. Conduct Motivational Interviewing to assess the client's stage of preparation for change; intervene accordingly, moving from building motivation, through strengthening commitment to change, to participation in treatment (see *Motivational Interviewing* by Miller and Rollnick; *Motivational Interviewing and Enhancement* by DiClemente, Van Orden, and Wright).
11. Ask the client to make a list of the ways substance abuse has negatively impacted his/her life (e.g., personally, medically, relationally, legally, vocationally, and socially) and the positive impact nonuse may have (or assign "Substance Abuse Negative Impact Versus Sobriety's Positive Impact" in the *Adult Psychotherapy Homework Planner* by Jongsma; or "Consequences of Continuing Addictive Lifestyles" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
12. Assign the client to complete an Alcoholics Anonymous Step 1 paper admitting to powerlessness over mood-altering chemicals and present it in group therapy or to therapist for feedback (see *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
13. Teach the client about the Alcoholics Anonymous concept of a higher power and how this can assist in recovery (e.g., God can help with chronic pain or craving, regular prayer and meditation can reduce stress)

	(or assign the client to complete the Step 2 and Step 3 exercises from *The Alcoholism & Drug Abuse Patient Workbook* by Perkinson).
7. Commit self to an action plan directed toward termination of substance use. (14, 15, 16)	14. Encourage and support the client's self-efficacy for change toward the goal of developing an action plan for termination of substance use to which the client is willing to commit.
	15. Assign the client to write a list of reasons to be abstinent from addiction (or assign "Alternatives to Addictive Behavior" in the *Addiction Treatment Homework Planner* by Finley and Lenz).
	16. Develop an abstinence contract with the client regarding the termination of the use of his/her drug of choice; process the client's feelings related to the commitment.
8. Attend Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) meetings as frequently as necessary to support sobriety. (17)	17. Recommend that the client attend AA or NA meetings and report on the impact of the meetings; process messages the client is receiving.
9. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (18, 19)	18. Discuss the negative effects the client's substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.
	19. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends when working Steps 8 and 9 of the AA program.
10. Verbalize increased knowledge of alcoholism and the process of recovery. (20, 21)	20. Conduct or assign the client to attend a chemical dependence didactic series to increase his/her

	knowledge of the patterns and effects of chemical dependence; ask him/her to identify several key points attained from each didactic and process these points.
	21. Assign the client to read a workbook describing evidence-based treatment approaches to addiction recovery (e.g., *Overcoming Your Alcohol or Drug Problem* by Daley and Marlatt); use the readings to reinforce key concepts and practices throughout therapy.
11. Verbalize an understanding of factors that can contribute to development of chemical dependence and pose risks for relapse. (22, 23)	22. Assess the client's intellectual, personality, and cognitive vulnerabilities, family history, and life stresses that contribute to his/her chemical dependence.
	23. Facilitate the client's understanding of his/her genetic, personality, social, and family factors, including childhood experiences that led to the development of chemical dependency and serve as risk factors for relapse.
12. Identify level of happiness in various areas of life. (24)	24. Approaching the client with empathy and genuine caring, administer the Happiness Scale (see *A Community Reinforcement Approach to Addiction Treatment* by Meyers and Miller); review results in session.
13. Develop goals to increase satisfaction and pleasure in unsatisfactory, nondrinking areas of life. (25)	25. Assist the client in defining specific goals and strategies for achieving increased happiness in problematic, nondrinking areas of life, so that the role of alcohol and/or drugs as the major determinant of an individual's

happiness is diminished (consider administering the Pleasant Activities List or assigning "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

14. Learn and implement communication and problem-solving skills toward achieving goals. (26, 27, 28, 29, 30)

26. Using modeling, role-playing, and behavioral rehearsal, teach the client communication skills including how to make statements that convey understanding, accepting partial responsibility for problems, and offering to help solve the problem.

27. Teach the client problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties' satisfaction with the action, adjust action if necessary); use role-playing to assist the client in applying these steps to life issues to increase happiness (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma).

28. Teach the client assertiveness skills that can be used to support substance use refusal.

29. Assign the client to read about general social and/or assertiveness skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).

15. Cooperate with exploration of increasing satisfaction in areas of life that can support sobriety such as employment, recreation, and relationships. (31, 32, 33, 34, 35)

30. Assign homework to encourage the client to apply the newly learned behavioral skills to achieving the happiness goals identified (see "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma); review progress, reinforcing success and redirecting for failure.

31. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process with the client (or assign "Assessing My Environment" from the *Addiction Treatment Homework Planner* by Finley and Lenz).

32. Facilitate development of a plan for the client to change his/her living situation to foster recovery (or assign "Assessing My Needs" in the *Addiction Treatment Homework Planner* by Finley and Lenz); revisit routinely and facilitate toward accomplishing a positive change in living situation.

33. Teach the client skills necessary for finding a job, keeping a job, and improving satisfaction in a job setting.

34. Assist the client in identifying new sources of nondrinking recreation and social friendships (or assign "Alternatives to Addictive Behavior" in the *Addiction Treatment Homework Planner* by Finley and Lenz); use problem-solving and communication skills to overcome obstacles.

16. Participate in behavioral couples therapy designed to increase the non-substance-using partner's reinforcement of sobriety and to reduce relationship conflict. (36, 37, 38, 39)

35. Direct conjoint sessions that address and resolve issues with a partner so as to increase the number of pleasant interactions and reduce conflicts.

36. Develop a sobriety contract with the couple that stipulates an agreement to remain abstinent, limits the focus of partner discussions to present-day issues, not past hurtful behaviors, identifies the role of AA meetings, and schedules a daily time to share thoughts and feelings.

37. Ask each partner to make a list of pleasurable activities that could be engaged in together to increase positive feelings toward each other (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the list and assign implementation of one or more activities before the next session.

38. Teach the couple problem-solving skills (identify and pinpoint the problem, brainstorm possible solutions, list and evaluate the pros and cons of each solution, select and implement a solution, evaluate all parties' satisfaction with the action, adjust action if necessary); role-play the use of these skills applied to real-life issues of conflict for the couple (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

39. In light of the recovery contract, review the client's sobriety experience and the couples' interaction since the last session; address any relationship conflicts, assisting the couple in improving their communication skills (e.g., "I messages," reflective listening, eye contact, respectful responding, etc.) by using role-play in the session.

17. Identify, challenge, and replace destructive, high-risk self-talk with positive, strength-building self-talk. (40, 41, 42)

40. Explore the client's schema and high-risk self-talk that weaken his/her resolve to remain abstinent; challenge the biases; assist him/her in generating realistic self-talk that correct for the biases and build resilience.

41. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success.

42. Assign the client a homework exercise in which he/she identifies high-risk self-talk, identifies biases in the self-talk, generates alternatives, and tests through behavioral experiments (consider assigning "Replacing Fears With Positive Messages" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

18. Earn rewards by submitting drug-negative urine samples. (43)

43. Implement a prize-based contingency management system for drug free living by rewarding

	the client's drug-negative urine samples with desired prizes starting at the low end of a $1–$100 range and increasing with continued abstinence (see *Contingency Management for Substance Abuse Treatment* by Petry).
19. Verbalize an understanding of lapse and relapse. (44, 45)	44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial, temporary, and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.
	45. Evaluate past lapses and prescribe self-monitoring to assess current risk factors for lapses (or assign "Identifying Relapse Triggers and Cues" in the *Addiction Treatment Homework Planner* by Finley and Lenz; and/or the *Alcoholism and Drug Abuse Patient Workbook* by Perkinson).
20. Implement relapse prevention strategies for managing possible future situations with high risk for relapse. (46, 47, 48, 49)	46. Use stimulus control techniques such as avoidance of specific triggers to reduce exposure to high-risk situations.
	47. Use instruction, modeling, imaginal rehearsal, role-play, and cognitive restructuring to teach the client cognitive-behavioral skills (e.g., relaxation, problem-solving, social and communication skills, recognition and management of rationalization, denial, and apparently irrelevant decisions) for managing urges and other high-risk situations.

48. Instruct the client to routinely use strategies learned in therapy (e.g., problem-solving, stimulus control, social skills, and assertiveness) while managing high-risk trigger situations (or assign "Aftercare Plan Components" in the *Adult Psychotherapy Homework Planner* by Jongsma).

49. Assist the client in developing a detailed, written recovery plan (e.g., treatment activities, daily routine, basic self-care, relationships, spirituality, work stress, finances, family issues, etc.) that will identify supports and strategies that will be used in maintaining sobriety (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

21. Verbalize the results of turning problems over to God each day. (50)

50. Using a Step 3 exercise, teach the client about the recovery concept of *turning it over*; then assign turning over problems to a higher power each day; ask the client to record the event and discuss the results.

22. Complete a survey to assess the degree of satisfaction with treatment. (51)

51. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	305.60	Cocaine Abuse
	305.30	Hallucinogen Abuse
	305.90	Inhalant Abuse
	305.50	Opioid Abuse
	305.90	Phencyclidine Abuse
	305.70	Amphetamine Abuse
	305.00	Alcohol Abuse
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
	303.90	Alcohol Dependence
	304.40	Amphetamine Dependence
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.50	Hallucinogen Dependence
	304.60	Inhalant Dependence
	304.00	Opioid Dependence
	304.90	Phencyclidine Dependence
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
	V71.01	Adult Antisocial Behavior
	309.81	Posttraumatic Stress Disorder
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
305.30	F16.10	Other Hallucinogen Use Disorder, Mild
304.50	F16.20	Other Hallucinogen Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F16.10	Phencyclidine Use Disorder, Mild
304.90	F16.20	Phencyclidine Use Disorder, Moderate or Severe

305.70	F15.10	Amphetamine-Type Use Disorder, Mild
304.40	F15.20	Amphetamine-Type Use Disorder, Moderate or Severe
305.40	F13.10	Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
291.2	F10.27	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type
291.1	F10.26	Moderate or Severe Alcohol Use Disorder With Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type
V71.01	Z72.811	Adult Antisocial Behavior
309.81	F43.10	Posttraumatic Stress Disorder
301.7	F60.2	Antisocial Personality Disorder

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

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

SUICIDAL IDEATION

BEHAVIORAL DEFINITIONS

1. Reports recurrent thoughts of and preoccupation with death.
2. Reports recurrent or ongoing suicidal ideation without any plans.
3. Expresses ongoing suicidal ideation with a specific plan.
4. Presents with chemical dependency or addiction that exacerbates depression, hopelessness, and suicidal ideation.
5. Reports losses due to addiction (e.g., financial, familial, vocational), which leave the client feeling suicidal and hopeless about his/her life.
6. Verbalizes belief that everyone would be better off if he/she were dead.
7. Has a history of suicide attempts.
8. Verbalizes profound feelings of helplessness, hopelessness, and worthlessness.
9. Reports the loss of a significant other to suicide or death, and has recurrent fantasies about joining the other person.
10. Expresses a bleak, hopeless attitude regarding life, coupled with recent losses that support this belief (e.g., divorce, death of spouse, illness, loss of job).

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LONG-TERM GOALS

1. Resolve preoccupation with death, find new hope, and enter a program of recovery, free of addiction and suicidal ideation.

2. Terminate all suicidal urges, express hope for the future, and remain abstinent from all mood-altering substances.
3. Placement at the level of care necessary to protect the client from his/her suicidal impulses.
4. Understand the relationship between suicidal ideation and addiction.
5. Develop a sense of worth to other addicts and family members.

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SHORT-TERM OBJECTIVES

1. Verbalize specific suicidal thoughts, feelings, plans, and actions. (1, 2)

2. Complete psychological testing or objective questionnaires for assessing suicidal ideation. (3)

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7)

THERAPEUTIC INTERVENTIONS

1. Assess the dangerousness of the suicidal ideation by asking the client to share suicidal feelings, thoughts, plans, and behaviors.
2. Explore the client's reasons for suicidal ideation: feelings of helplessness, hopelessness, and worthlessness.
3. Administer to the client psychological instruments designed to objectively assess suicidal ideation (e.g., Beck Depression Inventory—II, Beck Scale for Suicide Ideation); give the client feedback regarding the results of the assessment and retest, if necessary, to assess treatment progress.
4. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is

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

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).
6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.
7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

4. Sign a no-self-harm contract and agree to contact a staff member if feeling suicidal. (8)

8. Have the client sign a no-self-harm contract that states that he/she will do nothing to harm himself/herself while in treatment, and that he/she will contact a staff member if feeling suicidal (or assign "Problem-Solving and Safety Planning" from the *Addiction Treatment Homework Planner* by Finley and Lenz).

5. Agree to the level of care that is necessary to protect self from suicidal impulses. (9, 10)

9. Discuss the levels of care that are available (e.g., locked room, staying close by a staff member, transfer to a more intensive level of care); admit the client to the level of care that will be necessary to protect him/her from suicidal impulses.

10. Assign a staff member to stay with the client until his/her suicidal threat is resolved.

6. Participate in an evidence-based therapy. (11)

11. Assess the client for an identifiable clinical syndrome or personality disorder (e.g., depression, borderline personality, bipolar disorder); refer him/her to the appropriate evidence-based psychotherapeutic intervention (see relevant chapters in this *Planner*).

7. Verbalize an understanding of how suicide risk is magnified by addiction. (12)

12. Assist the client in understanding how feelings of shame, loss, and hopelessness are exacerbated by addictive behavior.

8. Identify the losses sustained because of addiction. (13)

13. Review the losses (e.g., marital, familial, social, legal, financial, health, occupational) that have resulted from addictive behavior and have led to suicidal hopelessness.

9. Verbalize feeling a sense of importance to family members and other addicts in recovery. (14, 15)

10. Meet with a physician for an assessment for the need for psychotropic medication. (16)

11. Take all medications as directed. (17, 18)

12. Keep a record of self-defeating thoughts, and replace each dysfunctional thought with positive, self-enhancing self-talk. (19, 20)

14. Help the client to see the meaning behind the 12-step recovery program's saying, "What we cannot do alone, we can do together"; help the client to see that other addicts need his/her support in recovery.

15. Review the client's role of importance to family and friends (or assign "Why Do I Matter and Who Cares?" in the *Addiction Treatment Homework Planner* by Finley and Lenz); confront minimization or disconnecting.

16. Refer the client to a physician to examine him/her, discuss suicidal ideation and addiction, order medications as indicated, titrate medications, and monitor for side effects.

17. Direct the staff to administer the client's prescribed medications.

18. Monitor the client's medication for compliance, effectiveness, and side effects.

19. Assist the client in developing an awareness of his/her cognitive messages that reinforce hopelessness and helplessness; assign him/her to keep a daily record of self-defeating thoughts such as thoughts of hopelessness, helplessness, worthlessness, catastrophizing, or negatively predicting the future (or assign "Journal of Distorted, Negative Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

20. Challenge each of the client's self-defeating thoughts for accuracy; replace each

	dysfunctional thought with a thought that is positive and self-enhancing (or assign "Negative Thoughts Trigger Negative Feelings" or "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
13. List the reasons for new hope for the future. (21, 22, 23)	21. Provide the client with reasons for new hope in recovery (e.g., being in treatment offers hope, working with trained professionals who can act as an advocate, other addicts can encourage him/her, staff members are supportive).
	22. Encourage the client regarding the excellent chances for recovery from addiction and depression if he/she works the 12-step program.
	23. Assign the client to read "the promises" on pages 83 and 84 of the Alcoholics Anonymous (AA) *Big Book*; encourage him/her to verbalize hope for the future.
14. List reasons for wanting to live. (24, 25)	24. Help the client to list reasons to live (e.g., positive people, places, things that are a part of his/her life).
	25. Assign the client to write a list of the positive people, places, and things in his/her life.
15. Verbalize new hope for resolving interpersonal conflicts because of being in addiction treatment. (26, 27)	26. Help the client to see the new hope that addiction treatment brings to the resolution of interpersonal conflicts.
	27. Meet with the client and a significant other with whom there is conflict to begin a process of conflict resolution.

16. Verbalize an understanding of the 12-step *attitude of gratitude*; list five things to be grateful for each day. (28)

17. Verbalize coping strategies that will elevate depressed mood. (29)

18. Encourage someone else in recovery at least once a day. (30)

19. Verbalize an understanding of the 12-step program's concept of a higher power, and how this can be used to recover from suicidal ideation and addictive behavior. (31, 32)

20. List three things that each family member can do to assist the client in recovery. (33, 34)

21. Complete a survey to assess the degree of satisfaction with treatment. (35)

28. Teach the client about the 12-step recovery program's concept of the *attitude of gratitude*; assign him/her to list five things for which he/she is grateful for each day.

29. Assist the client in developing coping strategies for suicidal ideation such as more physical exercise, less internal focus, increased social involvement, and more expression of feelings (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma).

30. Assign the client to encourage someone in treatment each day; record each event and discuss with the therapist.

31. Teach the client about the 12-step recovery program's concept of a higher power; encourage the client to ask a higher power for direction each day.

32. Assign the client to read Chapter 11 in *Twelve Steps and Twelve Traditions* (AA); encourage him/her to pray and meditate at least once each day.

33. In a family session, have the client discuss the connection between suicidal ideation and addiction.

34. Help the client to list three things that each family member can do to assist him/her in recovery; assign the client to share these with the family members and report back to the therapist.

35. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Major Depressive Disorder
	300.4	Dysthymic Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	309.0	Adjustment Disorder With Depressed Mood
	291.89	Alcohol-Induced Mood Disorder
	292.84	Amphetamine-Induced Mood Disorder
	292.84	Cocaine-Induced Mood Disorder
	292.84	Inhalant-Induced Mood Disorder
	292.84	Opioid-Induced Mood Disorder
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Axis II:	301.83	Borderline Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
296.4x	F31.4	Bipolar I Disorder, Depressed, Severe
296.89	F31.81	Bipolar II Disorder
309.0	F43.21	Adjustment Disorder With Depressed Mood
291.89	F10.24	Alcohol-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder
292.84	F15.24	Amphetamine-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder

292.84	f14.24	Cocaine-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder
292.84	F18.24	Inhalant-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder
292.84	F11.24	Opioid-Induced Depressive Disorder With Moderate or Severe Alcohol Use Disorder
301.83	F60.3	Borderline Personality Disorder

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

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

TREATMENT RESISTANCE

BEHAVIORAL DEFINITIONS

1. Verbalizes severe denial of addiction in spite of strong evidence of loss of control, withdrawal symptoms, and many negative consequences of addiction.
2. Substitutes a secondary problem as the focus of concern rather than admit that addiction is the primary problem.
3. Demonstrates anger toward family members, court, or employer for giving an ultimatum for treatment.
4. Refuses to cooperate with the staff and remains a constant risk of leaving treatment against medical advice.
5. Is verbally abusive toward others, irritable, restless, and angry.
6. Demonstrates dishonesty to self and others rather than to the facts regarding own addiction.
7. Constantly uses the telephone to make demands of a friend or family member to come and take him/her out of treatment.
8. Refuses to talk to or bond with treatment peers.

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LONG-TERM GOALS

1. Accept the truth about the problems that addiction has caused, and enter a program of recovery.
2. Accept the powerlessness and unmanageability that addiction has brought to life, and actively engage in the treatment process.

3. Learn the facts about addiction, and make a logical decision about the treatment necessary to arrest it.
4. Cooperate with addiction assessments and accept the diagnosis and treatment plan.
5. Resolve anger at others and accept responsibility for the problems caused by addiction and for the need for treatment.
6. Cooperate with medical management for withdrawal, and agree to enter a 12-step program of recovery.

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SHORT-TERM OBJECTIVES

1. Share the feelings that surround admission to treatment. (1, 2)

2. Cooperate with a biopsychosocial assessment and accept the treatment recommendations. (3)

3. Complete psychological testing or objective questionnaires for assessing treatment resistance. (4)

THERAPEUTIC INTERVENTIONS

1. Probe the reasons why the client is resisting treatment; check for the accuracy of his/her beliefs about addiction.
2. Encourage the client to share the fear, sadness, shame, and anger that he/she feels about coming for treatment.
3. Conduct a biopsychosocial assessment, and collect laboratory results and collateral information from friends and relatives; share these results with the client.
4. Administer to the client psychological instruments designed to objectively assess treatment resistance (e.g., Correctional Treatment Resistance Scale, Therapeutic Reactance Scale); give the client feedback regarding the results of the assessment and retest, if

necessary, to assess treatment progress.

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

5. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational,

	vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Cooperate with a physician's examination. (9)	9. Refer the client to a physician to examine the client and share the results of the client's history and physical, pointing out signs and symptoms of prolonged and excessive addiction.
6. Listen to the results of the assessments, and make a rational, informed choice about the treatment that is needed to arrest addiction. (10, 11, 12)	10. Using the biopsychosocial and medical assessments, help the client to make an informed choice about addiction treatment.
	11. Discuss the levels of care that are available (e.g., recovery group meetings, counseling, outpatient treatment, intensive outpatient, day treatment, residential treatment) and help the client to make an informed decision about entering treatment.
	12. Teach the client about the treatment process, and encourage him/her to stay in treatment as long as necessary to bring the addiction under control.
7. Provide data for a Stage of Change assessment. (13)	13. Assess the client's position in the Stage of Change (see *Substance Abuse Treatment and the Stages of Change* by Conners, Donovan, and DiClemente); provide feedback of results (or assign "Assessing Readiness and Motivation" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

8. List times when addictive behavior led to negative consequences. (14)

14. Help the client to see the extent of his/her addiction by assisting him/her in listing a number of negative consequences that have resulted from addictive behavior (or assign "Problem Identification" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

9. Concerned family members, friends, employer, and/or coworkers express their concerns about the client's addiction. (15, 16)

15. Ask the client to sign releases of information and to meet with his/her employer, family, friends, and/or coworkers to enlist their support for him/her to remain in treatment.

16. Ask concerned family, friends, employer, and coworkers to write letters, stating specific instances when the client's addiction hurt them, and to share what they are going to do if the client refuses treatment; if possible, have each person read the letters to the client in a group setting.

10. Sign a release of information to the probation, parole, or court services worker so information can be shared concerning treatment. (17)

17. Ask the client to sign a release of information, and contact his/her probation, parole, or court services worker to elicit support for treatment.

11. Discuss the reasons for treatment resistance with treatment peers, and listen to their feedback. (18, 19)

18. In a group setting, encourage the client to share why he/she does not want to remain in treatment; facilitate other clients' confrontation of denial and support for the need for treatment.

19. Encourage the client to discuss with peers and staff his/her plans to leave treatment.

12. Stay with a staff member or treatment buddy until the threat of leaving treatment resolves. (20)

20. Assign a staff member or treatment peer to stay with the client until the risk of leaving treatment is resolved.

13. List lies that were told to hide addiction. (21)

14. Develop a written personal recovery plan that includes the treatment that is necessary to maintain abstinence. (22)

15. Make a list of things that each family member can do to assist the client in recovery. (23, 24)

16. Complete a survey to assess the degree of satisfaction with treatment. (25)

21. Help the client to admit to the lies that he/she told to hide his/her addiction.

22. Help the client to develop a written personal recovery plan detailing the treatment that is necessary to maintain abstinence (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

23. In a family session, teach the family members the role of denial in treatment resistance and addiction.

24. Help the client to list three things that each family member can do to assist in recovery; facilitate a sharing of these with family members.

25. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	305.00	Alcohol Abuse
	305.70	Amphetamine Abuse
	305.20	Cannabis Abuse
	305.60	Cocaine Abuse
	305.30	Hallucinogen Abuse

	305.90	Inhalant Abuse
	305.50	Opioid Abuse
	305.90	Phencyclidine Abuse
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
	303.90	Alcohol Dependence
	304.40	Amphetamine Dependence
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.50	Hallucinogen Dependence
	304.60	Inhalant Dependence
	304.00	Opioid Dependence
	304.90	Phencyclidine Dependence
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
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Axis II:	301.7	Antisocial Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
305.00	F10.10	Alcohol Use Disorder, Mild
305.70	F15.10	Amphetamine-Type Substance Use Disorder, Mild
305.20	F12.10	Cannabis Use Disorder, Mild
305.60	F14.10	Cocaine Use Disorder, Mild
305.30	F16.10	Other Hallucinogen Use Disorder, Mild
305.90	F18.10	Inhalant Use Disorder, Mild
305.50	F11.10	Opioid Use Disorder, Mild
305.90	F16.10	Phencyclidine Use Disorder, Mild
305.40	F13.10	Sedative, Hypnotic, Anxiolytic Use Disorder, Mild
03.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.70	F15.20	Amphetamine-Type Substance Use Disorder, Moderate or Severe
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
304.50	F16.20	Other Hallucinogen Use Disorder, Moderate or Severe
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe

304.60	F16.20	Phencyclidine Use Disorder, Moderate or Severe
304.10	F13.20	Sedative, Hypnotic, Anxiolytic Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder

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

UNIPOLAR DEPRESSION

BEHAVIORAL DEFINITIONS

1. Feels sad or down most of the days of the week.
2. Engages in addictive behavior as a means of escaping from feelings of sadness, worthlessness, and helplessness.
3. Presents with vegetative symptoms (e.g., sleep disturbance, appetite disturbance, anhedonia, lack of energy, weight change).
4. Verbalizes persistent feelings of helplessness, hopelessness, worthlessness, and/or guilt.
5. Lacks energy and has excessive fatigue.
6. Reports poor concentration, indecisiveness.
7. Demonstrates low self-esteem.
8. Experiences mood-congruent hallucinations or delusions.
9. Reports suicidal thoughts.
10. Expresses a wish to die without a suicidal thought or plan.

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LONG-TERM GOALS

1. Elevate mood and develop a program of recovery free from addiction.
2. Understand affective disorders and how these symptoms increase vulnerability to addiction.
3. Develop a program of recovery that includes healthy exercise, relaxation, and eating and sleeping habits.

4. Alleviate depressive symptoms and return to previous level of effective functioning.
5. Develop healthy thinking patterns and beliefs about self, others, and the world that lead to the alleviation and help prevent the relapse of depression.
6. Develop healthy interpersonal relationships that lead to the alleviation of, and help prevent the relapse of, depression.
7. Appropriately grieve the loss in order to normalize mood and to return to previously adaptive level of functioning.

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SHORT-TERM OBJECTIVES

1. Describe current and past experiences with depression and other mood episodes, including their impact on function and attempts to resolve or treat them. (1, 2)

2. Facilitate an assessment of personal and family history of depression and other mood symptoms, allowing family participation. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Assess current and past mood episodes including their features, frequency, intensity, and duration; impact on role functioning; previous treatments; and response to treatments (e.g., Clinical Interview supplemented by the Inventory to Diagnose Depression).
2. Utilize a graphic display, such as a timeline, to help the client identify the pattern of his/her mood symptoms.
3. Ask family, friends, and caregivers about the client's own and the family's history of depression symptoms.
4. Provide the client, family, or caretaker with sleeping, eating, and activity logs on which to document current levels of functioning.

3. Complete psychological testing to assess the depth of depression, the need for antidepressant medication, and suicide prevention measures. (5)

4. Cooperate with suicide prevention measures. (6, 7)

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. (8, 9, 10, 11)

5. Arrange for the administration of an objective assessment instrument for evaluating the client's depression and suicide risk (e.g., Beck Depression Inventory—II and/or Beck Hopelessness Scale); evaluate results and give feedback to the client; re-administer as needed to assess treatment response.

6. Coordinate an immediate referral to a crisis residential facility or inpatient psychiatric ward to provide a safe, supervised environment for the suicidal client.

7. Develop a structured suicide prevention plan (see the Suicidal Ideation chapter in this *Planner*).

8. Assess the client's level of insight (syntonic versus dystonic) toward the presenting problems (e.g., demonstrates good insight into the problematic nature of the described behavior, agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the problem described and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the problem described, is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with 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).

10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined problem behavior and factors that could offer a better understanding of the client's behavior.

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

6. Verbalize the powerlessness and unmanageability that result from using addictive behavior to cope with depression. (12, 13)

12. Using a 12-step recovery program's Step 1 exercise, help the client to admit powerlessness and unmanageability over addictive behavior and depression (or assign "Consequences of Continuing Addictive Lifestyles" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

13. Teach the client that addictive behavior results in negative psychological effects such as depression and that addiction is often used to escape from these same psychological symptoms, creating a vicious cycle.

7. Identify a pattern of using drug or alcohol abuse as a means of escaping from depression, and verbalize more constructive means of coping. (14, 15)

14. Confront the client's addictive behavior as a means of coping with depression; assist him/her in identifying the self-defeating, negative consequences of this behavior.

15. Process healthier, more constructive means of coping with depression such as sharing pain with others, attending 12-step recovery program meetings, developing positive cognitions, taking medication, turning conflicts over to a higher power, practicing gratitude (or assign "Gratitude" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

8. Cooperate with a referral to a physician for a psychotropic medication evaluation. (16)

16. Refer the client to a physician for an evaluation as to the need for psychotropic medications.

9. Take prescribed psychotropic medications responsibly; report the side effects and effectiveness of medications to the appropriate professional. (17)

17. Educate the client about the use and expected benefits of medication; review effects of the medications with the client and medical staff to identify possible side effects; monitor the client's medication compliance and effectiveness.

10. Verbalize an accurate understanding of depression. (18, 19)

18. Consistent with the treatment model, discuss how cognitive, behavioral, interpersonal, biochemical, and/or other factors (e.g., family history) contribute to depression.

19. Assign the client to read chapters, books, treatment manuals, or other resources that convey psychoeducational concepts regarding depression and its treatment (e.g., *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by

McKay, Davis, and Fanning; *A Cognitive Behavioral Workbook for Depression: A Step-by-Step Program* by Knaus; *The Mindfulness and Acceptance Workbook for Depression* by Strosahl and Robinson; *The Interpersonal Solution to Depression: A Workbook for Changing How You Feel by Changing How You Relate* by Pettit, Joiner, and Rehm).

11. Verbalize an understanding of the rationale for treatment of depression. (20)

20. Consistent with the treatment model, discuss how changes in cognitive, behavioral, interpersonal, and other factors can help clients alleviate depression and return to previous level of effective functioning.

12. Identify and replace thoughts and beliefs that support depression. (21, 22, 23, 24)

21. Conduct Cognitive-Behavioral Therapy (see *Cognitive Behavior Therapy: Basics and Beyond* by Beck), beginning with helping the client learn the connection between cognition, depressive feelings, and actions.

22. Assign the client to self-monitor thoughts, feelings, and actions in daily journal (e.g., "Correcting Distorted Thinking" in the *Addiction Treatment Homework Planner* by Finley and Lenz; or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck et al.); process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts.

23. Assign behavioral experiments in which depressive automatic thoughts are treated as hypotheses/predictions, reality-based alternative hypotheses/

predictions are generated, and both are tested against the client's past, present, and/or future experiences.

24. Facilitate and reinforce the client's shift from biased depressive self-talk and beliefs to reality-based cognitive messages that enhance self-confidence and increase adaptive actions (see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

13. Learn and implement behavioral strategies to overcome depression. (25, 26)

25. Engage the client in behavioral activation, increasing his/her activity level and contact with sources of reward while identifying processes that inhibit activation (or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, role reversal, as needed, to facilitate activity in the client's daily life; reinforce success.

26. Assist the client in developing skills that increase the likelihood of deriving pleasure from behavioral activation (e.g., assertiveness skills, developing an exercise plan, less internal/more external focus, increased social involvement); reinforce success (recommend *Overcoming Depression One Step at a Time: The New Behavioral Activation Approach to Getting Your Life Back* by Addis and Martell).

14. Identify important people in life, past and present, and describe the quality, good and poor, of those relationships. (27)

15. Verbalize an understanding and resolution of current interpersonal problems. (28, 29, 30, 31)

27. Conduct Interpersonal Therapy (see *Comprehensive Guide to Interpersonal Psychotherapy* by Weissman, Markowitz, and Klerman) beginning with the assessment of the client's interpersonal inventory of important past and present relationships; develop a case formulation linking depression to grief, interpersonal role disputes, role transitions, and/or interpersonal deficits (or assign *The Interpersonal Solution to Depression: A Workbook for Changing How You Feel by Changing How You Relate* by Pettit, Joiner, and Rehm).

28. For grief, facilitate mourning and gradually help the client discover new activities and relationships to compensate for the loss.

29. For interpersonal disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

30. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role.

31. For interpersonal deficits, help the client develop new interpersonal skills and relationships. EBP

16. Learn and implement problem-solving and decision-making skills. (32, 33) EBP

32. Conduct Problem-Solving Therapy (see *Problem-Solving Therapy* by D'Zurilla and Nezu) using techniques such as psychoeducation, modeling, and role-playing to teach the client problem-solving skills (i.e., defining a problem specifically, generating possible solutions, evaluating the pros and cons of each solution, selecting and implementing a plan of action, evaluating the efficacy of the plan, accepting or revising the plan); role-play application of the problem-solving skill to a real life issue (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBP

33. Encourage in the client the development of a positive problem orientation in which problems and solving them are viewed as a natural part of life and not something to be feared, despaired, or avoided. EBP

17. Learn and implement conflict resolution skills to resolve interpersonal problems. (34, 35) EBP

34. Teach conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use psychoeducation, modeling, role-playing, and rehearsal to work through several current conflicts; assign homework exercises; review and repeat so as to integrate their use into the client's life. EBP

35. Help the client resolve depression related to interpersonal problems through the use of reassurance and support, clarification of cognitive and affective triggers that ignite conflicts, and active problem-solving (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

18. Learn and implement relapse prevention skills. (36, 37, 38)

36. Discuss with the client the distinction between a lapse and a relapse, associating a lapse with a rather common, temporary setback that may involve, for example, re-experiencing a depressive thought and/or urge to withdraw or avoid (perhaps as related to some loss or conflict) and a relapse as a sustained return to a pattern of depressive thinking and feeling usually accompanied by interpersonal withdrawal and/or avoidance.

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

38. Build the client's relapse prevention skills by helping him/her identify early warning signs of relapse and rehearsing the use of skills learned during therapy to manage them.

19. Implement mindfulness techniques for relapse prevention. (39, 40, 41)

39. Use mindfulness meditation and cognitive therapy techniques to help the client learn to recognize and regulate the negative thought processes associated with depression and to change his/her relationship with these thoughts (see *Mindfulness-Based*

Cognitive Therapy for Depression by Segal, Williams, and Teasdale).

40. Assign reading material to the client that explains mindfulness and acceptance therapy for depression (e.g., *The Mindfulness and Acceptance Workbook for Depression* by Strosahl and Robinson).

41. Work to increase the client's new sense of well-being by building his/her personal strengths evident in their progress through therapy (or assign "Acknowledging My Strengths" and/or "What Are My Good Qualities?" in the *Adult Psychotherapy Homework Planner* by Jongsma).

20. Participate in couples therapy to decrease depression and improve the relationship. (42)

42. Conduct Behavioral Couples Therapy using behavioral interventions focused on exchanges between partners including assertive communication, and problem-solving/conflict resolution; focus on consistent use of respectful assertive communication, increasing caring exchanges between partners, and fostering collaborative problem-solving (see *Integrative Couple Therapy* by Jacobson and Christensen).

21. Verbalize an understanding of healthy and unhealthy emotions with the intent of increasing the use of healthy emotions to guide actions. (43)

43. Use a process-experiential approach consistent with Emotion-Focused Therapy to create a safe, nurturing environment in which the client can process emotions, learning to identify and regulate unhealthy feelings and to generate more adaptive ones that then guide

actions (see *Emotion-Focused Therapy for Depression* by Greenberg and Watson).

22. Verbalize insight into how past relationships may be influencing current experiences with depression. (44, 45, 46, 47)

44. Conduct Brief Psychodynamic Therapy for depression to help the client increase insight into the role that past relational patterns may be influencing current vulnerabilities to depression; identify core conflictual themes; process with the client toward making changes in current relational patterns (see *Supportive-Expressive Dynamic Psychotherapy of Depression* by Luborsky et al.).

45. Explore experiences from the client's childhood that contribute to current depressed state.

46. Encourage the client to share feelings of anger regarding pain inflicted on him/her in childhood that contributed to current depressed state.

47. Help client gain insight into the connection between previously unexpressed (repressed) feelings of anger (and helplessness) and current state of depression.

23. Use mindfulness and acceptance strategies to reduce experiential and cognitive avoidance and increase value-based behavior. (48)

48. 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 than change or control symptoms, and behave according to his/her broader life values; assist the client in clarifying his/her goals and values and commit to behaving accordingly.

24. Write an autobiography detailing the exact nature of wrongs, and turn past misbehavior over to a higher power. (49)

25. Write an aftercare program. (50)

26. Complete a survey to assess the degree of satisfaction with treatment. (51)

49. Using a 12-step recovery program's Step 4 inventory, assign the client to write an autobiography that details exactly how he/she has hurt others; help him/her turn over past misbehavior to a higher power.

50. Help the client to develop a written aftercare program that includes regular attendance at 12-step recovery groups and any other therapy that the client needs to improve his/her health (or assign "Personal Recovery Planning" in the *Addiction Treatment Homework Planner* by Finley and Lenz).

51. Administer a survey to assess the client's degree of satisfaction with treatment.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	309.0	Adjustment Disorder With Depressed Mood
	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
	311	Depressive Disorder NOS
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	300.4	Dysthymic Disorder
	301.13	Cyclothymic Disorder

	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	295.70	Schizoaffective Disorder
	V62.82	Bereavement
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

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

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
309.0	F43.21	Adjustment Disorder With Depressed Mood
309.28	F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
311	F32.9	Unspecified Depressive Disorder
311	F32.8	Other Specified Depressive Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
300.4	F34.1	Persistent Depressive Disorder
301.13	F34.0	Cyclothymic Disorder
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
V62.82	Z63.4	Uncomplicated Bereavement
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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

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

Appendix A

BIBLIOTHERAPY SUGGESTIONS

General

Many references are made throughout the chapters to four therapeutic homework resources especially relevant to counseling with adults and adolescents struggling with addiction and mental health issues. Rather than cite them repeatedly, they are cited here under the General heading:

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Appendix B

REFERENCES TO EMPIRICAL SUPPORT AND CLINICAL RESOURCES FOR EVIDENCE-BASED CHAPTERS

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Conduct Disorder/Delinquency

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Partner Relational Conflicts

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Selected Studies and Reviews of Empirical Support for Emotionally/Emotion-Focused Couples Therapy

Empirical Support

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[Roberts et al., 2009 and Rose et al., 2002 are reviews concluding that routine use of psychological intervention or debriefing after exposure traumatic events to try to prevent the development of PTSD may have adverse effects on some individuals and should not be used.]

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Relapse Proneness

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Appendix C

RECOVERY MODEL OBJECTIVES AND INTERVENTIONS

The Objectives and Interventions below are created around the 10 core principles developed by a multidisciplinary panel at the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004):

1. *Self-direction*: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

2. *Individualized and person-centered*: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

3. *Empowerment*: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual

gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

4. *Holistic*: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. *Nonlinear*: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. *Strengths-based*: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. *Peer support*: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. *Respect*: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. *Responsibility*: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. *Hope*: Recovery provides the essential and motivating message of a better future—that people can overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.[1]

The numbers used for objectives in the following treatment plan correspond to the preceding numbers for the core principles. Each of the 10 objectives was written to capture the essential theme of the like-numbered core principle. The numbers in parentheses after the objectives denote the interventions designed to assist the client in attaining each respective objective. The clinician may select any or all of the objectives and intervention statements to include in the client's treatment plan.

One generic long-term goal statement is offered should the clinician desire to emphasize a recovery model orientation in the client's treatment plan.

LONG-TERM GOALS

1. To live a meaningful life in a self-selected community while striving to achieve full potential during the journey of healing and transformation.

SHORT-TERM OBJECTIVES

1. Make it clear to therapist, family, and friends what path to recovery is preferred. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Explore the client's thoughts, needs, and preferences regarding his/her desired pathway to recovery from (depression, bipolar disorder, posttraumatic stress disorder [PTSD], etc.).
2. Discuss with the client the alternative treatment

[1] From: Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center: Center for Mental Health Services (2004). *National consensus statement on mental health recovery.* Washington, DC: Author. Retrieved from http://store.samhsa.gov/shin/content/sma05-4129/SMA05-4129.pdf

	interventions and community support resources that might facilitate his/her recovery. 3. Solicit from the client his/her preferences regarding the direction treatment will take; allow for these preferences to be communicated to family and significant others. 4. Discuss and process with the client the possible outcomes that may result from his/her decisions.
2. Specify any unique needs and cultural preferences that must be taken under consideration during the treatment process. (5, 6)	5. Explore with the client any cultural considerations, experiences, or other needs that must be considered in formulating a mutually agreed-upon treatment plan. 6. Modify treatment planning to accommodate the client's cultural and experiential background and preferences.
3. Verbalize an understanding that decision-making throughout the treatment process is self-controlled. (7, 8)	7. Clarify with the client that he/she has the right to choose and select among options and participate in all decisions that affect him/her during treatment. 8. Continuously offer and explain options to the client as treatment progresses in support of his/her sense of empowerment, encouraging and reinforcing the client's participation in treatment decision-making.
4. Express mental, physical, spiritual, and community needs and desires that should be integrated into the treatment process. (9, 10)	9. Assess the client's personal, interpersonal, medical, spiritual, and community strengths and weaknesses. 10. Maintain a holistic approach to treatment planning by integrating the client's unique

	mental, physical, spiritual, and community needs and assets into the plan; arrive at an agreement with the client as to how these integrations will be made.
5. Verbalize an understanding that during the treatment process there will be successes and failures, progress and setbacks. (11, 12)	11. Facilitate realistic expectations and hope in the client that positive change is possible, but does not occur in a linear process of straight-line successes; emphasize a recovery process involving growth, learning from advances as well as setbacks, and staying this course toward recovery.
	12. Convey to the client that you will stay the course with him/her through the difficult times of lapses and setbacks.
6. Cooperate with an assessment of personal strengths and assets brought to the treatment process. (13, 14, 15)	13. Administer to the client the Behavioral and Emotional Rating Scale (BERS): A Strength-Based Approach to Assessment.
	14. Identify the client's strengths through a thorough assessment involving social, cognitive, relational, and spiritual aspects of the client's life; assist the client in identifying what coping skills have worked well in the past to overcome problems and what talents and abilities characterize his/her daily life.
	15. Provide feedback to the client of his/her identified strengths and how these strengths can be integrated into short-term and long-term recovery planning.
7. Verbalize an understanding of the benefits of peer support during the recovery process. (16, 17, 18)	16. Discuss with the client the benefits of peer support (e.g., sharing common problems, receiving advice regarding

	successful coping skills, getting encouragement, learning of helpful community resources, etc.) toward the client's agreement to engage in peer activity.
	17. Refer the client to peer support groups of his/her choice in the community and process his/her experience with follow-through.
	18. Build and reinforce the client's sense of belonging, supportive relationship building, social value, and community integration by processing the gains and problem-solving the obstacles encountered through the client's social activities.
8. Agree to reveal when any occasion arises that respect is not felt from the treatment staff, family, self, or the community. (19, 20, 21)	19. Discuss with the client the crucial role that respect plays in recovery, reviewing subtle and obvious ways in which disrespect may be shown to or experienced by the client.
	20. Review ways in which the client has felt disrespected in the past, identifying sources of that disrespect.
	21. Encourage and reinforce the client's self-concept as a person deserving of respect; advocate for the client to increase incidents of respectful treatment within the community and/or family system.
9. Verbalize acceptance of responsibility for self-care and participation in decisions during the treatment process. (22)	22. Develop, encourage, support, and reinforce the client's role as the person in control of his/her treatment and responsible for its application to his/her daily life; adopt a supportive role as a resource person to assist in the recovery process.

10. Express hope that better functioning in the future can be attained. (23, 24)

23. Discuss with the client potential role models who have achieved a more satisfying life by using their personal strengths, skills, and social support to live, work, learn, and fully participate in society toward building hope and incentive motivation.

24. Discuss and enhance internalization of the client's self-concept as a person capable of overcoming obstacles and achieving satisfaction in living; continuously build and reinforce this self-concept using past and present examples supporting it.

Appendix D

CLIENT SATISFACTION SURVEYS: RESOURCE MATERIAL

Each chapter in the book has a list of objectives and interventions; at the end of the list they refer to completing or administering a client satisfaction survey. Following are listed references to examples of surveys that may be purchased and used for assessing client satisfaction. Dr. C. Attkisson has published considerable research on this issue, and others have used his scales in their research and agency outcome studies. Attkisson has developed scales with 3, 4, 8, 18, and 31 items.

Other surveys are also used in gathering information about clients' satisfaction with mental health services. The following are references to survey material. Some of this material is copyrighted and must be purchased, while other survey items are available for general use. Please contact the authors to ask about using their survey material.

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Appendix E

ASAM SIX ASSESSMENT DIMENSIONS: A CHECKLIST EXAMPLE

DIMENSION 1: DETOXIFICATION/WITHDRAWAL (ACUTE INTOXICATION/WITHDRAWAL POTENTIAL)

Signs and symptoms indicate the continued presence of the intoxication or withdrawal problem that required admission to the present level of care.

- ❑ Patient was monitored for acute withdrawal symptoms and received medication(s).
- ❑ Patient was monitored for acute withdrawal symptoms and did not receive medication for withdrawal.
- ❑ Patient completed acute detoxification and no complications were noted.
- ❑ Patient completed acute detoxification and withdrawal was prolonged.
- ❑ Patient received education on protracted withdrawal symptoms.
- ❑ Patient did not require detoxification at the time of admission.

COMMENTS: _____

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

The patient's status in Dimension 2 is characterized by *one* of the following:

YES	NO		
_____	_____	a.	The interaction of the patient's biomedical condition and continued alcohol or other drug use places the patient in imminent danger of serious damage to physical health or concomitant biomedical conditions; *or*
_____	_____	b.	A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment.

Patient was treated for the following medical problems:

❑ Hypertension	❑ Chronic Pain Syndrome	❑ Sleep Pattern Disturbance	❑ Hepato-megaly
❑ COPD/ Asthma/ Emphysema	❑ Diabetes	❑ Cardio-vascular Problems	❑ Headaches
❑ Back Problems	❑ Anemia	❑ Pancreatitis	❑ Arthritis/ Gout
❑ Upper Respiratory Infection	❑ Thyroid Problems	❑ Bowel Problems	❑ Ulcers
❑ Gastritis	❑ Urinary Tract Infection	❑ GERD	❑ Sinus Infection
			❑ Hepatitis

❑ Other _____

❑ Other _____

❑ Admission Laboratory Work Completed ❑ Repeat Laboratory Work Completed ❑ N/A

❑ Urine Chemical Screening Completed: ❑ Positive ❑ Negative ❑ Not Available at the Present Time

❑ History and Physical Completed

❑ TB Mantoux Given: ❑ Positive ❑ Negative

❑ Patient was given psychotropic medications—see Dimension 3 for further information.

COMMENTS: _____

DIMENSION 3: EMOTIONAL/BEHAVIORAL CONDITIONS AND COMPLICATIONS

Affect or Mood (Check all that are appropriate):

❑ Appropriate	❑ Labile	❑ Restless	❑ Poor Impulse Control
❑ Euphoric	❑ Cooperative	❑ Pressured Speech	❑ Anxious
❑ Sad	❑ Homicidal Plan	❑ Manic	❑ Angry
❑ Homicidal Ideation	❑ Panic Attacks	❑ Flat	❑ Suicidal Plan
❑ Poor Concentration	❑ Apathetic	❑ Suicidal Ideation	❑ Depressed
❑ Requires Ongoing Boundary Setting	❑ Aggressive	❑ Paranoid Thoughts	
❑ Inappropriate	❑ Argumentative	❑ Obsessive-Compulsive Thoughts	
	❑ Irritable		

Patient had a psychiatric evaluation by a psychiatrist:

❑ Yes ❑ No ❑ Scheduled but Pending

Patient received a prescription for psychotropic medications:

❑ Yes ❑ No ❑ Scheduled but Pending

Medications were prescribed for the following psychiatric conditions:

_____

COMMENTS: _____

DIMENSION 4: READINESS TO CHANGE

The patient's status in this dimension is characterized by *one* of the following:

YES	NO		
_____	_____	a.	Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the patient does not accept or relate the addictive disorder to the severity of these problems; *or*

_____ _____ b. The patient is in need of intensive strategies, activities, and processes available only in a 24-hour structured, medically monitored setting; *or*

_____ _____ c. The patient needs ongoing, 24-hour psychiatric monitoring to assure follow-through with the treatment regimen and to deal with issues such as ambivalence about compliance with psychiatric medications.

Attendance:	❑ Poor	❑ Fair	❑ Good	❑ Excellent
Attitude:	❑ Poor	❑ Fair	❑ Good	❑ Excellent
Group Participation:	❑ Poor	❑ Fair	❑ Good	❑ Excellent
Honesty:	❑ Poor	❑ Fair	❑ Good	❑ Excellent
Acceptance:	❑ Poor	❑ Fair	❑ Good	❑ Excellent
Commitment/Motivation:	❑ Poor	❑ Fair	❑ Good	❑ Excellent

During the past week the patient worked on the following assignments (Check all that apply):

Chemical Use History: ❑ Problem Assessment ❑ Millon ❑ Quickview

❑ Beck Depression Inventory ❑ Honesty Exercise ❑ Step 1 ❑ Step 2

❑ Step 3 ❑ Step 4 ❑ Step 5 ❑ Gambling Assessments

❑ Other _____

Patient Visited with Staff Clergy: ❑ Yes ❑ No

Patient Attended Church: ❑ Yes ❑ No

COMMENTS: _____

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

The patient's status in this dimension is characterized by *one* of the following:

YES	NO		
_____	_____	a.	Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the patient does not accept or relate the addictive disorder to the severity of these problems; *or*
_____	_____	b.	The patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, *or*
_____	_____	c.	The modality of treatment or protocols to address relapse require that the patient stay in treatment.

Relapse Potential Is:	❑ High	❑ Moderate	❑ Low
Worked on a Peer Pressure Exercise:	❑ Yes	❑ No	❑ Pending
Worked on Identifying Relapse Triggers:	❑ Yes	❑ No	❑ Pending
Developed a Relapse Prevention Exercise:	❑ Yes	❑ No	❑ Pending
Patient Has Pending Legal Issues:	❑ Yes	❑ No	❑ Pending
Had Contact with Patient's Probation Officer:	❑ Yes	❑ No	❑ Pending

COMMENTS: _____

DIMENSION 6: RECOVERY ENVIRONMENT

The patient's status in this dimension is characterized by *one* of the following:

YES	NO		
_____	_____	a.	The patient's current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; *or*

_____ _____ b. Family members or significant others living with the patient are not supportive of his/her recovery goals and are actively sabotaging treatment; *or*

_____ _____ c. The patient is unable to cope, for even limited periods of time.

It is appropriate to retain the patient at the present level of care if:

_____ _____ 1. The patient's current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; *or*

_____ _____ 2. The patient is not yet making progress, but has the capacity to resolve his/her problems. He/she is actively working toward the goals articulated in his/her individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; *and/or*

_____ _____ 3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient's new problems can be addressed effectively.

Patient Developed a Relapse Prevention Plan:

❑ Yes ❑ No ❑ Pending

Patient Agreed to Participate in AA/NA/GA Meetings Post Discharge:

❑ Yes ❑ No

Patient Given a Name for a Temporary AA/NA/GA Contact:

❑ Yes ❑ No ❑ Pending

Patient Agreed to Attend Aftercare Meetings Post Discharge:

❑ Yes ❑ No ❑ Pending

If Yes, at What Facility: _____

Patient Has Agreed to Attend Individual Counseling Post Discharge:

❑ Yes ❑ No ❑ Pending N/A Patient Refuses

If Yes, at What Facility: _____

Patient Has Agreed to Attend Marital Counseling Post Discharge:

❑ Yes ❑ No ❑ Pending N/A Patient Refuses

If Yes, at What Facility: _____

Employer Has Been Contacted:

❑ Yes ❑ No ❑ Pending N/A Patient Refuses

Family/Significant Other Was Contacted:

❑ Yes ❑ No ❑ Pending N/A Patient Refuses

Family Program Scheduled:

❑ Yes (Dates._____) ❑ No ❑ Pending ❑ Patient Refuses

Halfway House Placement Is Being Recommended for the Patient:

❑ Yes ❑ No ❑ Pending N/A Patient Refuses

Patient Returning Home:

❑ Yes ❑ No ❑ Pending N/A Patient Refuses

COMMENTS: _____

_____ _____

Primary Therapist Signature Date

Appendix F

ALPHABETICAL INDEX OF SOURCES FOR ASSESSMENT INSTRUMENTS AND CLINICAL INTERVIEW FORMS CITED IN INTERVENTIONS

Title
    Author(s)
        Publisher, Source, or Citation

16 Personality Factors Questionnaire (16pf)
    Cattell, Cattell, and Cattell
        Pearson

Addiction Severity Index (ASI)
    McLellan, Luborsky, O'Brien, and Woody
        McLellan, A. T., Luborsky, L., O'Brien, C. P. & Woody, G. E. (1980). An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous & Mental Diseases*, 168, 26–33. Available from http://adai.washington.edu/instruments/pdf/Addiction_Severity_Index_Baseline_Followup_4.pdf

ADHD Rating Scale-IV (ADHD-RS-IV)
    DuPaul, Power, Anastopoulos, and Reid
        Guilford Press

Adolescent Psychopathology Scale-Short Form (APS-SF)
    Reynolds
        PAR

Affective Disorders Evaluation (ADE)
Sachs
Bipolar Disorders

Aggressive Acts Questionnaire (AAQ)
Buss and Warren
WPS

Anger, Irritability, and Assault Questionnaire (AIAQ)
Coccaro, Harvey, Kupsaw-Lawrence, Herbert, and Bernstein
Coccaro, E. F., Harvey, P. D., Kupsaw-Lawrence, E., Herbert, J. L., & Bernstein, D. P. (1991). Development of neuropharmacologically based behavioral assessments of impulsive aggressive behavior. *The Journal of Neuropsychiatry and Clinical Neurosciences, 3(2),* 44-51.

Anxiety Disorders Interview Schedule–Adult Version (ADIS)
Brown, DiNardo, and Barlow
Oxford University Press

Barratt Impulsiveness Scale-11 (BIS-11)
Barratt
Fifty years of the Barratt Impulsiveness Scale: An update and review. Stanford, M. S., Mathias, C. W., Dougherty, D. M., Lake, S. L., Anderson, N. E., & Patton, J. H. (2009) *Personality and Individual Differences*, *47*, 385–395. Available from http://www.impulsivity.org/measurement/bis11

Beck Depression Inventory—FastScreen for Medical Patients (BDI-FastScreen)
Beck, Steer, and Brown
Pearson

Beck Anxiety Inventory (BAI)
Beck
Pearson

Beck Depression Inventory–II (BDI-II)
Beck, Steer, and Brown
Pearson

Beck Hopelessness Scale (BHS)
Beck
Pearson

Beck Scale for Suicide Ideation (BSS)
Beck
Pearson

Behavioral and Emotional Rating Scale (BERS)
Epstein
Epstein, M. H., & Sharma, J. (1998). *Behavioral and Emotional Rating Scale (BERS): A Strength-Based Approach to Assessment.* Austin, TX: PRO-ED.

Buss-Durkee Hostility Inventory (BDHI)
Buss and Durkee
Buss, A. H., & Durkee, A. (1957). An inventory for assessing different kinds of hostility. *Journal of Counseling Psychology, 21*, 343–349.

Child Behavior Checklist (CBCL)
Achenbach
ASEBA

Child Behavior Inventory (ecbi)
Eyberg and Pincus
PAR

Childhood Trauma Questionnaire (CTQ)
Bernstein and Fink
Pearson

Children of Alcoholics Screening Test (CAST)
Jones, J. W. (1983). *Children of Alcoholics Screening Test* (CAST). Chicago, IL: Camelot Unlimited. Available from: http://www.ncsacw.samhsa.gov/files/TrainingPackage/MOD6/CAST.pdf

Clinical Institute Withdrawal Assessment of Alcohol Scale-Revised (CIWA-Ar)
Sullivan, Sykora, Schneiderman, Naranjo, & Sellers
Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction, 84*, 1353–1357.

Clinical Monitoring Form (CMF)
Sachs, Guille, and McMurrich
Sachs, G. S., Guille, C., & McMurrich, S. L. (2002). A clinical monitoring form for mood disorders. *Bipolar Disorders, 4*(5), 323–327.

Clinical Opiate Withdrawal Scale (COWS)
Wesson and Ling
Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *Journal of Psychoactive Drugs, 35*(2), 253–359.

Cognitive Capacity Screening Examination (CCSE)
Jacobs, Bernhard, Delgado, and Strain
Jacobs, J. W., Bernhard, M. R., Delgado, A., & Strain, J. J. (1977). Screening for organic mental syndromes in the medically ill. *Annals of Internal Medicine, 86,* 40–46.

Communication Patterns Questionnaire-Short Form (CPQ-SF)
Futris, T. G., Campbell, K., Nielsen, R. B., & Burwell, S. R. (2010). The Communication Patterns Questionnaire—Short Form: A review and assessment. *The Family Journal*, *18*. doi:10.1177?1066480710370758
Available from http://tfj.sagepub.com/content/18/3/275.full.pdf+html

Conners Adult ADHD Rating Scale (CAARS)
Conners, Erhardt, and Sparrow
Pearson

Coping With Health, Injuries, and Problems (CHIP)
Endler and Parker
MHS

Correctional Treatment Resistance Scale (CTRS)
Shearer and Ogan
Shearer, R. A., & Ogan, G. D. (2002). Measuring treatment resistance in offender counseling. *Journal of Addictions & Offender Counseling*, *22*, 72–82.

Davidson Trauma Scale (DTS)
Davidson
MHS

Derogatis Interview for Sexual Functioning (DISF)
Derogatis
Clinical Psychometric Research, Inc.

Disruptive Behavior Rating Scale (DBRS)
Erford
Slosson Educational Publishers

Domestic Violence Inventory (DVI)
Behavior Data Systems
Available from http://www.domestic-violence-inventory.com

Dyadic Adjustment Scale (DAS)
Spainer
MHS

Eating Disorder Scale/Yale-Brown-Cornell Eating Disorder Scale (YBC-EDS)
Mazure, Halmi, Sunday, Romano, and Eihorn
Mazure, C. M., Halmi, K. A., Sunday, S. R., Romano, S. J., & Einhorn, A. M. (1994). The Yale-Brown-Cornell Eating Disorder Scale: Development, use, reliability and validity. *Journal of Psychiatric Research*, *28*(5), 425–445.

Eating Disorders Inventory-3 (EDI-3)
Garner
PAR

Eating Inventory (EI)
Stunkard and Messick
Pearson

Fagerstrom Test for Nicotine Dependence (FTND)
Heatherton, Kozlowski, Frecker, and Fagerstrom
Heatherton, T. F., Kozlowski, L. T., Frecker, R. C., & Fagerstrom, K. (1991). The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addiction, 86*, 1119–1127.

Family Environment Scale (FES)
Moos and Moos
Mind Garden

Family Relationship Inventory (FRI)
Michaelson and Bascom
Psychological Publications

Family System Test (FAST)
Gehring
Available from http://www.fast-test.com

Grief Experience Inventory (GEI)
Sanders, Mauger, and Strong
Consulting Psychologists Press

Hamilton Anxiety Rating Scale (HARS)
Hamilton
Hamilton, M. (1959). The assessment of anxiety states by rating. *British Journal of Medical Psychology*, *32*, 50–55.

Hamilton Depression Rating Scale (HDRS)
Hamilton
Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry*, *23*, 56–62.

Impact of Events Scale-Revised (IES-R)
Weiss and Marmar
Weiss, D. S., & Marmar, C. R. (1996). The Impact of Event Scale–Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York, NY: Guilford Press. Available in above chapter and from: http://www.ptsd.va.gov/professional/pages/assessments/ies-r.asp

Independent Living Scales (ILS)
Loeb
Pearson

Inventory to Diagnose Depression/Diagnostic Inventory for Depression (IDD/DID)
Zimmerman and Coryell; Zimmerman, Sheeran, and Young
Zimmerman, M., & Coryell, W. (1987). The inventory to diagnose depression: A self-report scale to diagnose major depressive disorder. *Journal of Consulting and Clinical Psychology, 55*(1), 55–59.
Zimmerman, M., Sheeran, T., & Young, D. (2004). The Diagnostic Inventory for Depression: A self-report scale to diagnose DSM-IV major depressive disorder. *Journal of Clinical Psychology, 60*(1), 87–110. Available from: http://onlinelibrary.wiley.com/doi/10.1002/jclp.10207/pdf

Jesness Behavior Checklist (JBC)
Jesness
MHS

Liebowitz Social Anxiety Scale (LSAS)
Liebowitz
Available from http://asp.cumc.columbia.edu/SAD/

Marital Satisfaction Inventory-Revised (MSI-R)
Snyder
MHS

Maroondah Assessment Profile for Problem Gambling (G-MAP)
Loughnan, Pierce, and Sagris-Desmond
Acer

McGill Pain Questionnaire-Short Form-2 (MPQ-SF-2)
Melzack
Mapi Research Trust Available from: http://www.mapi-trust.org/services/questionnairelicensing/catalog-questionnaires/292-sf-mpq-2

Michigan Alcohol Screening Test (MAST)
Selzer

Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*(12), 1653–1658. Available from: http://www.projectcork.org/clinical_tools/html/MAST.html

Millon Adolescent Clinical Inventory (MACI)
Millon, Millon, David, and Grossman
Pearson

Millon Clinical Multiaxial Inventory-III (MCMI-III)
Millon
Pearson

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
Butcher et al.; Tellegen et al.; Ben-Porath et al.
Pearson

Multiphasic Sex Inventory-II (MSI-II)
Nichols and Molinder
Nichols & Molinder Assessments, Inc

Narcotic Withdrawal Scale (NWS)
Fultz and Senay
Fultz J. M. , & Senay, E. C. (1975). Guidelines for the management of hospitalized narcotics addicts. *Annals of Internal Medicine, 82*(6), 815–818.

Obsessive-Compulsive Inventory-Revised (OCI-R)
Foa et al.
Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., & Salkovskis, P. M. (2002). The obsessive-compulsive inventory: Development and validation of a short version. *Psychological Assessment, 14*(4), 485–496.

Parent-Child Relationship Inventory (PCRI)
Gerard
WPS

Parenting Stress Index (PSI)
Abidin
PAR

Penn State Worry Questionnaire (PSWQ)
Meyer, Miller, Metzger, and Borkovec
Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28,* 487–495. Available from: https://outcometracker.org/library/PSWQ.pdf

Perceived Criticism Measure (PCM)
Hooley and Teasdale
Hooley, J. M., & Teasdale, J. D. (1989). Predictors of relapse in unipolar depressives: Expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology, 98,* 229–235.

Posttraumatic Stress Diagnostic Scale (PDS)
Foa
Pearson

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)
Hasin and Samet
New York State Psychiatric Institute Available from: http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/52_PRISM.pdf

Psychopathy Checklist-Revised (PCL-R)
Hare
Pearson

PTSD Symptom Scale (PSS)
Foa, Riggs, Dansu, and Rothbaum
Foa, E., Riggs, D., Dancu, C., & Rothbaum, B. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Available from http://www.ptsd.va.gov/professional/pages/assessments/pss-i.asp

Quality of Life Inventory (QOLI)
Frish
Pearson

Sexual Adjustment Inventory (SAI)
Lindeman
Available from Sexual-adjustment-inventory.com

Short Michigan Alcoholism Screening Test (SMAST)
Journal of Studies on Alcohol
Rutgers Center of Alcohol Studies

Social Interaction Anxiety Scale (SIAS)
Mattick and Clarke
Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia, scrutiny fear, and social interaction anxiety. *Behaviour Research and Therapy, 36,* 455–470.

Social Phobia Inventory (SPIN)
Connor, Davidson, Churchill, Sherwood, Foa, and Weisler
Connor, K. M., Davidson, J. R., Churchill, L. E., Sherwood, A., Foa, E., & Weisler, R. H. (2000). Psychometric properties of the Social Phobia Inventory (SPIN). New self-rating scale. *British Journal of Psychiatry, 176,* 379–386.

South Oaks Gambling Screen (SOGS)
Lesieur and Blume
Lesieur, H. R., & Blume, S. B. (1987). *American Journal of Psychiatry*, *144*(9), 1184–1188.

Spiritual Well-Being Scale (SWBS)
Ellison and Paloutzian
Life Advance

State-Trait Anxiety Inventory (STAI)
Spielberger
PAR

State-Trait Anger Expression Inventory (STAXI)
Spielberger
PAR

Substance Abuse Relapse Assessment (SARA)
Schonfeld, Peters, and Dolente
Psychtest.com

Substance Abuse Subtle Screening Inventory-3 (SASSI-3)
Miller, Roberts, Brooks, Lazowski, and the SASSI Institute
Pearson

Substance Use Disorders Diagnostic Schedule-IV (SUDDS-IV)
Hoffmann and Harrison
Evince Clinical Assessments

Symptom Checklist-90-R (SCL-90-R)
Derogatis
Pearson

Therapeutic Reactance Scale (TRS)
Dowd, Milne, and Wise
Dowd, E. T., Milne, C. R., & Wise, S. L. (1991). The Therapeutic Reactance Scale: A measure of psychological reactance. *Journal of Counseling and Development*, *69*, 541–545.

Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)

Goodman et al.

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, *46*, 1006–1011.

Young Mania Rating Scale (YMRS)

Young, Biggs, Ziegler, and Meyer

Young, R. C., Biggs, J. T., Ziegler, V. E., & Meyer, D. A. (1978). A rating scale for mania: Reliability, validity, and sensitivity. *British Journal of Psychiatry*, *133*, 429–435.