ANGER MANAGEMENT

BEHAVIORAL DEFINITIONS

1. History of explosive aggressive outbursts out of proportion to any precipitating stressors leading to assaultive acts or destruction of property.
2. Overreaction of hostility to insignificant irritants.
3. Swift and harsh judgement statements made to or about others.
4. Body language of tense muscles (e.g., clenched fist or jaw, glaring looks, or refusal to make eye contact).
5. Use of passive-aggressive patterns (social withdrawal due to anger, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, or nonparticipation in meeting expected behavioral norms).
6. Consistent pattern of challenging or disrespectful treatment of authority figures.
7. Use of verbally abusive language.

LONG-TERM GOALS

1. Decrease overall intensity and frequency of angry feelings and increase ability to recognize and appropriately express angry feelings as they occur.
12 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER

2. Develop an awareness of current angry behaviors, clarifying origins of and alternatives to aggressive anger.
3. Come to an awareness and acceptance of angry feelings while developing better control and more serenity.
4. Become capable of handling angry feelings in constructive ways that enhance daily functioning.

---

SHORT-TERM OBJECTIVES

1. Verbally acknowledge that he/she is angry. (1, 2)
2. Identify targets of and causes for anger. (2, 3, 4)
3. Verbalize increased awareness of anger expression patterns. (2, 5, 6)
4. Verbalize how influential people in growing up have modeled anger expressions. (2, 7)
5. Identify pain and hurt of past or current life that fuels anger. (2, 8, 9)
6. Verbalize feelings of anger in a controlled, assertive way. (10, 11, 12, 17)
7. Decrease the number and duration of angry outbursts. (10, 13)
8. Utilize relaxation techniques to cope with angry feelings. (14)

THERAPEUTIC INTERVENTIONS

1. Assist patient in coming to the realization that he/she is angry.
2. Assign patient to read the book Of Course You’re Angry (Rosellini and Worden) or The Angry Book (Rubin).
3. Ask patient to keep a daily journal in which he/she documents persons, situations, and so on that cause anger, irritation, or disappointment.
4. Assign and process a thorough list of all targets of and causes for anger.
5. Confront/reflect angry behaviors that occur within sessions.
6. Refer patient to an anger management class or group.
7. Assist patient in identifying ways key life figures, such
9. Verbalize increased awareness of how past ways of handling angry feelings have had a negative impact. (13, 15, 16)

10. Decrease verbal and physical manifestations of anger, aggression, or violence while increasing awareness and acceptance of feelings. (12, 17)

11. Verbalize increased awareness of and ability to react to hot buttons or anger triggers in a nonaggressive manner. (10, 18, 19)

12. Write an angry letter to target of anger and process this letter with therapist. (20, 21)

13. Verbalize recognition of how holding on to angry feelings freezes you and hands control over to others and cite the advantages of forgiveness. (22, 23)

14. Write a letter of forgiveness to perpetrator of past or present pain and process this letter with therapist. (24)

15. Ask patient to list ways anger has negatively impacted him/her in daily life. Process list with patient.

as father, mother, and teachers, have expressed angry feelings and how positively or negatively these experiences have influenced the way patient handles anger.
16. Expand patient’s awareness of the negative affects that anger has on his/her body.

17. Use empty chair technique to coach patient in expressing angry feelings in a constructive, non-self-defeating manner.

18. Assist patient in developing the ability to recognize his/her hot buttons/triggers that lead to angry explosions.

19. Train patient in Rational Emotive Therapy (RET) techniques for coping with feelings of anger, frustration, and rage.

20. Ask patient to write an angry letter to parents, spouse, or whomever, focusing on the reasons for his/her anger toward that person. Process letter in session.

21. Encourage patient to express and release while in session feelings of anger or rage, and violent fantasies or plots for revenge.

22. Discuss forgiveness of perpetrators of pain as a process of letting go of anger.

23. Assign patient to read the book Forgive and Forget (Smedes).

DIAGNOSTIC SUGGESTIONS

Axis I:
- 312.43 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

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
ANTISOCIAL BEHAVIOR

BEHAVIORAL DEFINITIONS

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

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

LONG-TERM GOALS

1. Become more responsible for behavior and keep behavior within the acceptable limits of the rules of society.
2. Develop and demonstrate a healthy sense of respect for social norms, the rights of others, and the need for honesty.
3. Improve method of relating to the world, especially authority figures; be more realistic, less defiant, and more socially sensitive.
4. Come to an understanding and acceptance of the need for limits and boundaries on behavior.
5. Accept responsibility for own actions, including apologizing for hurts and not blaming others.
6. Maintain consistent employment and demonstrate financial and emotional responsibility for children.

ANTISOCIAL BEHAVIOR

THERAPEUTIC INTERVENTIONS

1. Explore the history of patient's pattern of illegal and/or unethical behavior and confront attempts at minimization, denial, or projection of blame.
1. Verbalize an understanding of the benefits for self and others of living within the laws and rules of society.

2. Make a commitment to live within the rules and laws of society.

3. List relationships that have been broken because of disrespect, disloyalty, aggression, or dishonesty.

4. Acknowledge a pattern of self-centeredness in virtually all relationships.

5. Verbalize an understanding of the benefits for self and others of being honest and reliable.

6. Make a commitment to be honest and reliable.

7. Verbalize an understanding of the benefits to self and others of being empathetic and sensitive to the needs of others.

8. List three actions that will be performed that will be acts of kindness and thoughtfulness toward others.


10. Indicate steps that will be taken to make amends or restitution for hurt caused to others.

11. Review the consequences for self and others of the antisocial behavior.

12. Teach that the basis for all relationships is trust that the other person will treat one with respect and kindness.

13. Teach the need for lawfulness as the basis for trust which forestalls anarchy in society as a whole.

14. Solicit a commitment to live a prosocial, law-abiding lifestyle.

15. Emphasize the reality of negative consequences for patient if continued lawlessness is practiced.

16. Review relationships that have been lost due to antisocial attitudes and practices (e.g., disloyalty, dishonesty, aggression, etc.).

17. Confront the lack of sensitivity to the needs and feelings of others.

18. Point out the self-focused, me-first, look-out-for-number-one attitude that is reflected in the antisocial behavior.

19. Teach the value of honesty and reliability for self as the basis for trust and respect in all relationships and social approval.

20. Teach the positive effect that honesty and reliability have for others as they are not disappointed or hurt by lies and broken promises.
12. Verbally demonstrate an understanding of the rules and duties related to employment. (19)

13. Attend work reliably and treat supervisor and coworkers with respect. (20, 21)

14. Verbalize the obligations of parenthood that have been ignored. (22, 23)

15. State a plan to meet responsibilities toward children. (23, 24)

16. Decrease statements of blame of others or circumstances for own behavior, thoughts, and feelings. (1, 17, 22, 25, 26)

17. Increase statements of accepting responsibility for own behavior. (16, 17, 18, 24, 27)

18. Describe instances in childhood of emotional, verbal, and/or physical abuse. (26, 28)

19. Verbalize an understanding of how childhood experiences of pain and aggression have led to an imitative pattern of self-focused protection and aggression toward others. (28, 29)

20. Verbalize a desire to forgive perpetrators of childhood abuse. (28, 29, 30)

21. Verbalize fears associated with trusting others. (28, 29, 31)

12. Ask patient to make a commitment to be honest and reliable.

13. Attempt to sensitize patient to his/her lack of empathy for others by revisiting consequences of behavior on others. Use role reversal techniques.

14. Confront patient when rude or not being respectful of others and their boundaries.

15. Assist patient in listing three actions that he/she will perform as acts of service or kindness for others.

16. Assist patient in identifying those who have been hurt by his/her antisocial behavior.

17. Teach the value of apologizing for hurt caused as a means of accepting responsibility for behavior and developing sensitivity to the feelings of others.

18. Encourage a commitment to specific steps that will be taken to apologize, make restitution to those who have suffered from patient’s hurtful behaviors.

19. Review the rules and expectations that must govern behavior at the work setting.

20. Monitor attendance at work and reinforce reliability as well as respect for authority.
21. Ask patient to make a list of behaviors and attitudes that must be modified in order to decrease his/her conflict with authorities. Process list with therapist.

22. Confront patient’s avoidance of responsibilities toward his/her children.

23. Assist patient in listing the behaviors that are required to be a responsible, nurturant, consistently reliable parent.

24. Develop a plan with patient that will begin to implement behaviors of a responsible parent.

25. Confront patient when making blaming statements or failing to take responsibility for actions, thoughts, or feelings.


27. Give verbal positive feedback to patient when he/she is taking responsibility for his/her own behavior.

28. Explore history of abuse, neglect, or abandonment in childhood.

29. Point out that the pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect self from pain.

30. Teach the value of forgiveness of the perpetrators of hurt versus holding on to
hurt and rage, using the hurt as an excuse to continue antisocial practices.

31. Explore fears associated with placing trust in others.

32. Identify some personal thoughts and feelings that could be shared with a significant other as a means of beginning to demonstrate trust in someone.

33. Process the experience of patient making self a little vulnerable by self-disclosing to someone.

DIAGNOSTIC SUGGESTIONS

**Axis I:**
- 303.90 Alcohol Dependence
- 304.20 Cocaine Dependence
- 304.89 Polysubstance Dependence
- 309.3 Adjustment Disorder with Disturbance of Conduct
- 312.8 Conduct Disorder
- 312.34 Intermittent Explosive Disorder

**Axis II:**
- 301.7 Antisocial Personality Disorder
- 301.81 Narcissistic Personality Disorder
BEHAVIORAL DEFINITIONS

1. Excessive and persistent daily worry about several life circumstances that has no factual or logical basis.
2. Symptoms of motor tension such as restlessness, tiredness, shakiness, or muscle tension.
3. Symptoms of autonomic hyperactivity such as palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, or diarrhea.
4. Symptoms of hypervigilance such as feeling constantly on edge, concentration difficulties, trouble falling or staying asleep, and general state of irritability.

LONG-TERM GOALS

1. Reduce overall level, frequency, and intensity of the anxiety so that daily functioning is not impaired.
2. Stabilize anxiety level while increasing ability to function on a daily basis.
3. Resolve the core conflict that is the source of anxiety.
4. Enhance ability to handle effectively the full variety of life's anxieties.
SHORT-TERM OBJECTIVES

1. Tell the story of the anxiety complete with ways he/she has attempted to resolve it and the suggestions others have given. (1, 2)

2. Identify major life conflicts from the past and present. (3, 4)

3. Complete anxiety homework exercises that identify cognitive distractions that generate anxious feelings. (5)

4. Complete physical evaluation for medications. (6)

5. Take medications as prescribed and report any side effects to appropriate professionals. (7)

6. Develop appropriate relaxation and diversion activities to decrease level of anxiety. (8, 9, 10)

7. Increase daily social and vocational involvement. (11)

8. Identify how worries are irrational. (12, 13)

THERAPEUTIC INTERVENTIONS

1. Build a level of trust with patient and create a supportive environment which will facilitate a description of his/her fears.

2. Probe with questions (see Anxiety Disorders and Phobias by Beck and Emery) which require the patient to produce evidence of the anxiety and logical reasons for it being present.

3. Ask patient to develop and process a list of key past and present life conflicts.

4. Assist patient in becoming aware of key unresolved life conflicts and in starting to work toward their resolution.

5. Assign patient to complete, and process with therapist, the anxiety section exercises in Ten Days to Self-Esteem! (Burns).

6. Make a referral to a physician for a medication consultation.
9. Increase understanding of beliefs and messages that produce worry and anxiety. (13, 14)

10. Verbalize insight into how past traumatic experiences are causing anxiety in present unrelated circumstances. (15)

11. Decrease daily level of anxiety by developing positive self-talk. (16)

12. Implement thought-stopping technique to interrupt anxiety-producing thoughts. (17)

13. List the advantages and disadvantages of the anxiety. (18)

14. Verbalize positive principles that reduce anxious thoughts. (19)

15. Verbalize alternative positive views of reality that are incompatible with anxiety-producing views. (20)

16. Identify an anxiety coping mechanism that has been successful in the past and increase its use. (21)

17. Utilize paradoxical intervention to reduce anxiety response. (22)


8. Train in guided imagery for anxiety relief.

9. Utilize biofeedback techniques to facilitate relaxation skills.

10. Assign or allow patient to choose a chapter in Relaxation and Stress Reduction Workbook (Davis, Eshelman, and McKay), then work with him/her to implement the chosen technique.

11. Assist patient in developing coping strategies (e.g., increased social involvement, obtaining employment, or physical exercise) for his/her anxiety.

12. Assist patient in developing an awareness of the irrational nature of his/her fears.

13. Analyze the fear with the patient by examining the probability of the negative expectation occurring, so what if it happens, ability to control it, the worst possible outcome, and the patient's ability to accept it. (See Anxiety Disorders and Phobias by Beck and Emery.)

14. Explore cognitive messages that mediate anxiety response and retrain in adaptive cognitions.
15. Reinforce insights into past emotional issues and present anxiety.

16. Help patient develop reality-based, positive cognitive messages that will increase self-confidence in coping with irrational fears.

17. Teach patient to implement a thought-stopping technique that cognitively interferes with obsessions by thinking of a stop sign and then a pleasant scene. Monitor and encourage patient's use of technique in daily life between sessions.

18. Ask patient to complete and process with therapist "Cost-Benefit Analysis" exercise (see Ten Days to Self-Esteem! by Burns) in which he/she lists the advantages and disadvantages of the negative thought, fear, or anxiety.

19. Read and process a fable from Friedman's Fables (Friedman) that pertains to anxiety with the patient.

20. Reframe the fear or anxiety by offering another way of looking at it, various alternatives, or by enlarging the perspective.

21. Utilize a brief solution-focused therapy approach in which the patient is probed to find a time or situation in his/her life when he/she handled the specific anxiety or an anxiety in general.
26. Clearly focus the approach he/she used and then encourage the patient to increase the use of this. Monitor and modify the solution as required.

22. Develop a paradoxical intervention (see Ordeal Therapy by Haley) in which the patient is encouraged to have the problem (e.g., anxiety) and then schedule that anxiety to occur at specific intervals each day in a specific way and for a defined length of time. It is best to have it happen at a time of day/night when the patient would be clearly wanting to do something else.

DIAGNOSTIC SUGGESTIONS

**Axis I:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.02</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>300.00</td>
<td>Anxiety Disorder NOS</td>
</tr>
<tr>
<td>309.24</td>
<td>Adjustment Disorder with Anxiety</td>
</tr>
</tbody>
</table>
ATTENTION DEFICIT DISORDER (ADD)—ADULT

BEHAVIORAL DEFINITIONS

1. Childhood history of Attention Deficit Disorder (ADD) that was either diagnosed or later concluded from by the symptoms of behavioral problems at school, impulsivity, overexcitability, temper outbursts, and lack of concentration.

2. Unable to concentrate or pay attention to things of low interest, even when those things are important to his/her life.

3. Easily distracted and drawn from task at hand.

4. Restless and fidgety; unable to be sedentary for more than a short time.

5. Impulsive; has an easily observable pattern of acting first, thinking later.

6. Rapid mood swings and mood lability within short spans of time.

7. Disorganized in most areas of his/her life.

8. Starts many projects but rarely finishes any.

9. Has a “low boiling point and a short fuse.”

10. Exhibits low stress tolerance; is easily frustrated, hassled or upset.


12. Tendency toward addictive behaviors.
LONG-TERM GOALS

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

SHORT-TERM OBJECTIVES

1. Cooperate with and complete psychological testing. (1, 2, 7)
2. Cooperate with and complete psychiatric evaluation. (3)
3. Comply with all recommendations of the psychiatric and/or psychological evaluations. (2, 4, 7)
4. Take medication as prescribed on a regular, consistent basis. (5, 6)
5. Identify specific benefits of taking prescribed medications on a long-term basis. (8, 9, 10)

THERAPEUTIC INTERVENTIONS

1. Arrange for the administration of psychological testing to establish or rule out Attention-Deficit/Hyperactivity Disorder (ADHD).
2. Process the results of psychological testing with patient to aid understanding and answer any questions which he/she may have.
3. Arrange for a psychiatric evaluation to make medication recommendations.
4. Process results and recommendations of psychiatric evaluation with patient and answer any questions that may arise.
6. Identify the specific ADD behaviors that cause self the most difficulty. (11, 12, 13)

7. Apply problem-solving skills to specific ADD behaviors that are interfering with daily functioning. (14, 15)

8. Utilize cognitive strategies to curb impulsive behavior. (16)

9. Implement a specific, time-limited period of indulging impulses that are not self-destructive. (17)

10. Use “time out” to remove self from situations and think about behavioral reaction alternatives and their consequences. (18)

11. Implement relaxation procedures to reduce tension and physical restlessness. (19)

12. Reward self when problem behaviors (e.g., impulsivity, inattention, etc.) are replaced with positive alternatives. (20)

13. Use lists, sticky notes, and daily routines to decrease effects of inattention. (21)

14. Cooperate with brainwave biofeedback to improve impulse control and reduce distractibility. (22, 23)

15. Introduce behaviors into life that improve health (e.g., increased exercise) and/or serve others (e.g., community service). (24, 25)

5. Monitor and evaluate medication compliance and the effectiveness of the medications on the patient’s level of functioning.

6. Confer with psychiatrist on regular basis regarding effectiveness of the medication regime.

7. Conduct a conjoint session with significant others and patient to present the results of psychological and psychiatric evaluations. Answer any questions they may have and solicit their support in dealing with patient’s condition.

8. Ask patient to make a “pros and cons” spreadsheet regarding staying on medications after doing well. Process sheet with therapist.

9. Encourage and support patient in remaining on medications and warmly but firmly confront thoughts of discontinuing when they surface.

10. Assign patient to list the positive effects that have occurred for him/her since starting on medication.

11. Assist patient in identifying the specific behaviors that cause him/her the most difficulty.

12. Review the results of psychological testing and/or psychiatric evaluation again with patient to assist
16. List the negative consequences of the ADD problematic behavior. (26)

17. Attend an ADD support group. (27)

18. Use a “coach” who has been trained by therapist to increase organization and task focus. (28, 29)

19. Report improved listening skills without defensiveness. (30)

20. Read material that is informative regarding ADD to gain knowledge about the condition. (31)

21. Decrease statements and feelings of negativity regarding self and life. (32)

22. Have significant other attend an ADD support group to increase his/her understanding of the condition. (33)

23. Attend a communication improvement group with significant other. (34)

24. Verbalize expectations partners have for each other. (35)

25. Report improved communication and feelings of trust between self and significant other. (34, 35, 36, 37)

26. Develop signals between partners to act as a warning system to indicate when problematic behaviors are escalating. (38)

27. Attend a communication improvement group with significant other. (34)

28. Verbalize expectations partners have for each other. (35)

29. Report improved communication and feelings of trust between self and significant other. (34, 35, 36, 37)

30. The Complete Adult Psychotherapy Treatment Planner

13. Ask patient to have extended family members and close colleagues complete a ranking of the three behaviors they see as interfering the most with his/her daily functioning (e.g., mood swings, temper outbursts, impulsivity, restlessness, easily stressed, short attention span, never completes projects, etc.).

14. Teach (or expand) patient’s problem-solving skills (i.e., identify problem, brainstorm all possible options, evaluate each option, select best option, implement course of action, and evaluate results).

15. Assign problem-solving homework to patient specific to identified behavior (i.e., impulse control, anger outbursts, mood swings, staying on task, attention). Process the completed assignment and give appropriate feedback to patient.

16. Teach patient the self-control strategies of “stop, listen, think, act” and “problem-solving self-talk.” Role-play these techniques to improve skill level.

17. Structure a “blow out” time each week when patient can do whatever he/she likes to
do that is not self-destructive (e.g., blast themselves with music, gorge on ice cream, etc.).

18. Train patient to use “timeout” intervention in which he/she settles down by going away from the situation and calming down to think about behavioral alternatives and their consequences.

19. Instruct patient in various relaxation techniques (e.g., deep breathing, meditation, guided imagery, etc.) and encourage patient to use daily or when stress increases.

20. Design and implement a self-administered reward system to reinforce and encourage patient’s decreased impulsiveness, loss of temper, inattentiveness, and so on.

21. Assist patient in utilizing external structure such as lists, reminders, files, and/or daily rituals to reduce effects of inattention and forgetfulness.

22. Refer for or administer brainwave biofeedback to improve attention span, impulse control, and mood regulation.

23. Encourage the patient to transfer the biofeedback training skills of relaxation and cognitive focusing to everyday situations (e.g., home, work, and social).
24. Direct patient toward healthy addictions such as exercise, volunteer work, or community service.

25. After clearance from patient's personal physician, refer patient to a physical fitness trainer who can design an aerobic exercise routine for the patient.

26. Assign patient to make a list of negative consequences either that he/she has experienced or that could result from the problematic behavior. Process list with therapist.

27. Refer to a specific group therapy for adults with ADD to increase patient's understanding of ADD, to boost his/her self-esteem, and to receive feedback from others.

28. Direct patient to pick a “coach” who is a friend or colleague to assist him/her in getting organized and staying on task and to give encouragement support. (See Driven to Distraction by Hallowell and Ratey.)

29. Instruct coach in HOPE technique (i.e., Help, Obligations, Plans, and Encouragement) as described in Driven to Distraction (Hallowell and Ratey).

30. Use role-playing and modeling to teach patient how to listen and accept feedback from others regarding his/her behavior.
31. Ask patient to read *Driven to Distraction* (Hallowell and Raty), *The Hyperactive Child, Adolescent and Adult* (Wender), *Putting On The Brakes* (Quinn and Stern); and/or *You Mean I’m Not Lazy, Stupid or Crazy* (Kelly and Ramundo). Process reading with therapist.

32. Conduct conjoint sessions in which positive aspects of the relationship, patient, and significant other are identified and affirmed.

33. Educate significant other on ADD and encourage him/her to attend a support group.

34. Refer patient and significant other to a skill-based marriage/relationship seminar (e.g., PREP, Marriage Encounter, Engaged Encounter, etc.) to improve communication and conflict resolution skills.

35. Ask patient and significant other to list the expectations they have for the relationship and each other. Process list in conjoint session with focus on identifying how expectations can be met and how realistic they are.

36. Assist patient and significant other in removing blocks in communication and in developing new communication skills.

37. Assign patient and significant other to schedule a specific time each day to
### Diagnostic Suggestions

#### Axis I:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>314.00</td>
<td>Attention-Deficit/Hyperactivity Disorder,</td>
</tr>
<tr>
<td></td>
<td>Predominately Inattentive Type</td>
</tr>
<tr>
<td>314.01</td>
<td>Attention-Deficit/Hyperactivity Disorder,</td>
</tr>
<tr>
<td></td>
<td>Predominately Hypersensitive-Impulsive Type</td>
</tr>
<tr>
<td>314.9</td>
<td>Attention-Deficit/Hyperactivity Disorder NOS</td>
</tr>
<tr>
<td>296.xx</td>
<td>Bipolar I Disorder</td>
</tr>
<tr>
<td>301.13</td>
<td>Cyclothymic Disorder</td>
</tr>
<tr>
<td>296.90</td>
<td>Mood Disorder NOS</td>
</tr>
<tr>
<td>312.30</td>
<td>Impulse Control Disorder NOS</td>
</tr>
<tr>
<td>303.90</td>
<td>Alcohol Dependence</td>
</tr>
<tr>
<td>305.00</td>
<td>Alcohol Abuse</td>
</tr>
<tr>
<td>304.30</td>
<td>Cannabis Dependence</td>
</tr>
<tr>
<td>305.20</td>
<td>Cannabis Abuse</td>
</tr>
</tbody>
</table>

34. THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER

- Assist patient and significant other in developing a signal system as a means of giving feedback when conflict behaviors begin to escalate.

- Spend together communicating, expressing affection, having fun, or talking through problems. Move assignment toward becoming a daily ritual.

38. Assist patient and significant other in developing a signal system as a means of giving feedback when conflict behaviors begin to escalate.
BO R DERL I N E P E R S O N A L I T Y

BEHAVIORAL DEFINITIONS

1. Extreme emotional reactivity (anger, anxiety, or depression) under minor stress that usually does not last more than a few hours to a few days.
2. A pattern of intense, chaotic interpersonal relationships.
4. Impulsive behaviors that are potentially self-damaging.
5. Recurrent suicidal gestures, threats, or self-mutilating behavior.
6. Chronic feelings of emptiness and boredom.
7. Frequent eruptions of intense, inappropriate anger.
8. Easily feels that others are treating him/her unfairly or that they can't be trusted.
9. Analyzes most issues in simple terms of right and wrong (e.g., 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.
LONG-TERM GOALS

1. Develop and demonstrate coping skills to deal with mood swings.
2. Develop the ability to control impulses.
3. Learn and demonstrate strategies to deal with dysphoric moods.
4. Replace dichotomous thinking with ability to tolerate ambiguity and complexity in people and issues.
5. Develop and demonstrate anger management skills.
6. Learn and practice interpersonal relationship skills.
7. Reduce the frequency of self-damaging behaviors (such as substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors).

SHORT-TERM OBJECTIVES

1. Verbalize the situations that can easily trigger feelings of fear, depression, and anger. (1)
2. Write a daily journal of feelings and the circumstances that triggered those feelings. (2)
3. Identify the negative cognitive interpretation patterns that mediate the intense negative emotions. (3, 4)
4. Verbalize realistic, positive self-talk to replace distorted negative messages. (4, 5, 6)
5. Record and report instances of implementing positive

THERAPEUTIC INTERVENTIONS

1. Explore the situations that trigger feelings of fear, depression, and anger.
2. Assign patient to record a daily journal of feelings along with the circumstances that he/she was reacting to.
3. Identify the distorted schemas and related automatic thoughts that mediate anxiety response.
4. Require patient to keep a daily record of self-defeating thoughts (thoughts of hopelessness, helplessness, worthlessness, catastrophiz-
self-talk and constructive automatic thoughts; include rewarding consequences. (6, 7)

6. List some negative consequences to self and others of self-defeating impulsive behaviors. (8)

7. Verbalize an understanding of the impulse control strategy of “stop, look, listen, and think.” (9)

8. Record and report instances of implementing “Stop, Look, Listen, and Think” as an impulse control strategy. (9, 10)

9. Utilize cognitive methods to control impulsive behavior. (9, 11)

10. Practice deep muscle relaxation and deep breathing exercises. (12)

11. Record and report instances of using relaxation techniques to manage intense feelings and control impulsive reactive behavior. (13)

12. Practice assertiveness skills. (14, 15)

13. Identify situations where assertiveness has been implemented and describe the consequences. (16)

14. Implement the use of “I messages” to communicate feelings without aggression. (17, 18)

15. Verbalize instances of abuse, neglect, or abandonment in childhood. (19)

BOORDERLINE PERSONALITY 37

...ing, negatively predicting the future, etc.), challenge each thought for accuracy, then replace each dysfunctional thought with one that is positive and self-enhancing.

5. Train in revising core schema using cognitive restructuring techniques.

6. Reinforce positive, realistic cognitive self-talk that mediates a sense of peace.

7. Assign patient to record instances of successfully using revised, constructive cognitive patterns. Process and reinforce positive consequences.

8. Assign patient to list destructive consequences to self and others of impulsive behavior.

9. Teach the patient mediational and self-control strategies (i.e., “stop, look, listen, and think”) to delay gratification and inhibit impulses.

10. Assign patient to record instances of successfully implementing “stop, look, listen, and think” to control reactive impulses.

11. Teach patient cognitive methods (thought stoppage, thought substitution, re-framing, etc.) for gaining and improving control over impulsive actions.
16. Verbalize the effect that childhood experiences of abuse, neglect, or abandonment has upon possessiveness in relationships and sensitivity to a hint of loss of commitment by others to relationship with self. (20, 21)

17. List coping strategies to deal with fear of abandonment. (22)

18. Initiate enjoyable activities that can be done alone or are not dependent on someone else to do them with. Report feeling comfortable being alone or independent. (4, 6, 23, 24)

19. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to stabilize mood. (25)

20. Take medication as prescribed and report as to effectiveness and side effects. (26)

21. Describe the history and nature of self-mutilating behavior. (27)

22. Verbalize the intense feelings that motivate self-mutilating behavior and how those feelings are relieved by such behavior. (19, 21, 28)

23. Verbalize the history of suicidal gestures and the feelings associated with them. (29)

12. Using relaxation techniques such as progressive relaxation, self-hypnosis, or biofeedback; teach the patient how to relax completely; then have the patient relax whenever he/she feels uncomfortable.

13. Ask patient to record instances of using relaxation techniques to cope with stress rather than reacting with anger. Reinforce successful implementation of this coping skill.

14. Use role-playing, modeling, and behavioral rehearsal to teach assertiveness (versus passivity and aggressiveness).

15. Refer patient to an assertiveness training group.

16. Review implementation of assertiveness and feelings about it as well as the consequences of it.

17. Use modeling, role-playing, and behavioral rehearsal to teach the use of “I messages” to communicate feelings directly (i.e., I feel . . . When you . . . I would prefer it if you . . .).

18. Reinforce the use of “I messages” in place of aggressiveness or possessiveness when feeling threatened.

19. Explore instances of abuse, neglect, or emotional/physical abandonment in childhood. Process the feelings associated with these experiences.
24. Verbalize a promise (as part of a self-mutilation and suicide prevention contract) to contact the therapist or some other emergency helpline if a serious urge toward self-harm arises. (30, 31)

25. Terminate all self-mutilation behavior. (21, 30, 32)

26. Identify instances where people were judged in black and white terms. (33, 35)

27. List negative consequences of judging people so rigidly and harshly. (34)

28. Verbalize weaknesses or faults of those who have been judged to be perfect and strengths or assets of those people who have been judged to be evil, worthless, and deceitful. (35, 36)

20. Point out the destructive effect of overcontrol of others and angry resentment when others pull back from relationship. Encourage separation of helpless, desperate feelings of the past from current relationships.

21. Reinforce insight into the effect of childhood experiences on current urges to react with rage.

22. Teach patient to use coping strategies (e.g., delay of reaction, “stop, look, listen, and plan,” relaxation and deep breathing techniques, “I messages,” expanded social network versus few intense relationships) to deal with fear of abandonment.

23. Explore patient’s automatic thoughts associated with being alone.

24. Encourage patient to break pattern of avoiding being alone by initiating activities without a companion (e.g., starting a hobby; doing exercise; attending lectures, concerts, movies; reading a book; taking a class).

25. Refer patient to a physician for medication evaluation.

26. Monitor and evaluate patient’s medication compliance and the effectiveness of the medication on the level of functioning.

27. Probe nature and history of patient’s self-mutilating behavior.
28. Interpret the self-mutilation as an expression of the rage and helplessness that could not be expressed as a child victim of emotional abandonment or abuse.

29. Assess the suicidal gestures as to triggers, frequency, seriousness, secondary gain, and onset.

30. Elicit a promise from the patient that he/she will initiate contact with the therapist or a helpline if the suicidal urge becomes strong and before any self-injurious behavior.

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

32. Encourage patient to express feelings directly using assertive “I messages” rather than indirectly through self-mutilating behavior.

33. Ask patient to examine his/her style of evaluating people, especially in regard to his/her dichotomous thinking.

34. Teach the alienating consequences of judging people harshly and impulsively.

35. Challenge the patient in understanding how dichotomous thinking leads to feelings of interpersonal mistrust, helping him/her to see positive and negative traits in all people.
36. Use role reversal and modeling to assist patient in seeing positive and negative qualities in all people.

DIAGNOSTIC SUGGESTIONS

Axis I:  
300.4  Dysthymic Disorder
296.3x Major Depressive Disorder, Recurrent

Axis II:  
301.83 Borderline Personality Disorder
301.9 Personality Disorder NOS
CHEMICAL DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Consistent use of alcohol or other mood-altering drugs until high, intoxicated, or passed out.
2. Inability 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. Blood work that reflects the results of a pattern of heavy substance use, for example, elevated liver enzymes.
4. Denial that chemical dependence is a problem despite direct feedback from spouse, relatives, friends, and employers that the use of the substance is negatively affecting them and others.
5. Amnesiac blackouts have occurred when abusing alcohol.
6. Continued drug and/or alcohol use despite experiencing persistent or recurring physical, legal, vocational, social, or relationship problems that are directly caused by the use of the substance.
7. Increased tolerance for the drug as there is the need to use more to become intoxicated or to attain the desired effect.
8. Physical symptoms, that is, shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, and/or depression, when withdrawing from the substance.
9. Suspension of important social, recreational, or occupational activities because they interfere with using.
10. Large time investment in activities to obtain the substance, to use it, or to recover from its effects.
11. Consumption of substance in greater amounts and for longer periods than intended.
12. Continued use of mood-altering chemical after being told by a physician that it is causing health problems.
SHORT-TERM OBJECTIVES

1. Describe the amount, frequency, and history of substance abuse. (1, 3)
2. Identify the negative consequences of drug and/or alcohol abuse. (1, 2, 3, 4, 13)

THERAPEUTIC INTERVENTIONS

1. Gather a complete drug/alcohol history including amount and pattern of use, signs and symptoms of use, and negative life consequences (social, legal, familial, and vocational).

LONG-TERM GOALS

1. Accept chemical dependence and begin to actively participate in a recovery program.
2. Establish a sustained recovery, free from the use of all mood-altering substances.
3. Establish and maintain total abstinence while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances and live a life free of chemicals.
5. Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals.
6. Withdraw from mood-altering substance, stabilize physically and emotionally, and then establish a supportive recovery plan.
3. Make verbal “I” statements that reflect acknowledgment and acceptance of chemical dependence. (5, 6, 7)

4. Decrease the level of denial around using as evidenced by fewer statements about minimizing amount of use and its negative impact on life. (2, 4, 6, 7)

5. Verbalize increased knowledge of alcoholism and the process of recovery. (6, 8)

6. Verbalize an understanding of personality, social, and family factors that foster chemical dependence. (9, 10, 11)

7. Describe childhood experience of alcohol abuse by immediate and extended family members. (11)

8. Review extended family alcohol use history and verbalize an acceptance of a genetic component to chemical dependence. (11, 12)

9. Obtain a medical examination to evaluate the effects of chemical dependence. (13)

10. Identify the ways being sober could positively impact life. (14)

11. State changes that will be made in social relationships to support recovery. (15, 16)

resulting from client’s chemical dependence.

2. Ask client to make a list of the ways substance abuse has negatively impacted his/her life and process it with therapist.

3. Administer the Alcohol Severity Index, and process the results with the client.

4. Assign client to ask two or three people who are close to him/her to write a letter to therapist in which they identify how they saw client’s chemical dependence negatively impacting his/her life.

5. Assign client to complete a First Step paper and then process it with either group, sponsor, or therapist to receive feedback.

6. Require client to attend didactic lectures related to chemical dependence and the process of recovery. Then ask client to identify in writing several key points attained from each lecture for further processing with therapist.

7. Model and reinforce statements that reflect acceptance of chemical dependence and its destructive consequences for self and others.

8. Assign client to read article/pamphlet on the disease concept of alcoholism and select several key ideas to discuss with therapist.
12. List recreational and social activities (and places) that will replace substance abuse related activities. (16, 17)

13. Identify constructive projects that will be accomplished now that time and energy are available in sobriety. (16, 18)

14. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (16, 19)

15. Identify the positive impact that sobriety will have on intimate and family relationships. (16, 20)

16. Verbalize how living situation contributes to chemical dependence and acts as a hindrance to recovery. (10, 21, 22)

17. State the need for a more stable, healthy living situation that will support recovery. (22, 23)

18. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (23, 24)

19. Write a goodbye letter to drug of choice telling it why it must go. (25)

20. Sign an abstinence contract and verbalize feelings of. fear, grief, or reluctance associated with signing. (26)

9. Assess client’s intellectual, personality, and cognitive functioning as to his/her contribution to chemical dependence.

10. Investigate situational stress factors that may foster client’s chemical dependence.

11. Probe client’s family history for chemical dependence patterns and relate these to client’s use.

12. Explore extended family chemical dependence history and relate this to a genetic vulnerability for client to develop chemical dependence also.

13. Refer client for thorough physical examination to determine any physical effects of chemical dependence.

14. Ask client to make and process a list of how being sober could positively impact life.

15. Review the negative influence of continuing old alcohol-related friendships (“drinking buddies”) and assist client in making a plan to develop new sober friendships.

16. Assist the client in developing insight into life changes needed in order to maintain long-term sobriety.

17. Assist client in planning social and recreational activities that are free from association with substance abuse.
21. Develop a written aftercare plan that will support the maintenance of long-term sobriety. (16, 17, 18, 27, 30)

22. Identify sources of ongoing support in maintaining sobriety. (28, 29, 30)

23. Meet with an Alcoholics Anonymous/Narcotics Anonymous (AA/NA) member to gain information about the role of AA/NA in recovery. (29)

24. Attend AA/NA meetings on a regular basis as frequently as necessary to support sobriety. (30)

25. Identify potential relapse triggers and develop strategies for constructively dealing with each trigger. (6, 10, 15, 17, 31, 32)

18. Plan household or work-related projects that can be accomplished to build self-esteem now that sobriety affords time and energy for such constructive activity.

19. Discuss the negative effects substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.

20. Assist client in identifying positive changes that will be made in family relationships during recovery.

21. Evaluate the role of client’s living situation in fostering a pattern of chemical dependence.

22. Assign client to write a list of negative influences for chemical dependence inherent in his/her current living situation.

23. Encourage a plan for a change in living situation that will foster recovery.

24. Reinforce a positive change in living situation.

25. Direct patient to write a good-bye letter to drug of choice; read it and process related feelings with therapist.

26. Develop an abstinence contract with patient regarding the use of his/her drug of choice. Then process the
emotional impact of this contract with therapist.

27. Assign and review patient's written aftercare plan to ensure it is adequate to maintain sobriety.

28. Explore with patient the positive support system personally available in sobriety and discuss ways to develop and reinforce a positive support system.

29. Assign patient to meet with an Alcoholic Anonymous/Narcotics Anonymous (AA/NA) member who has been working the Twelve-Step program for several years and find out specifically how the program has helped him/her stay sober. Afterward, process the meeting with therapist.

30. Recommend patient attend AA or NA meetings and report to therapist the impact of the meetings.

31. Help patient develop an awareness of relapse triggers and alternative ways of effectively handling them.

32. Recommend the patient read Staying Sober: A Guide to Relapse Prevention (Gorski and Miller) and The Staying Sober Workbook (Gorski).
## Diagnostic Suggestions

### Axis I:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>303.90</td>
<td>Alcohol Dependence</td>
</tr>
<tr>
<td>305.00</td>
<td>Alcohol Abuse</td>
</tr>
<tr>
<td>304.30</td>
<td>Cannabis Dependence</td>
</tr>
<tr>
<td>305.20</td>
<td>Cannabis Abuse</td>
</tr>
<tr>
<td>304.20</td>
<td>Cocaine Dependence</td>
</tr>
<tr>
<td>305.60</td>
<td>Cocaine Abuse</td>
</tr>
<tr>
<td>304.80</td>
<td>Polysubstance Dependence</td>
</tr>
<tr>
<td>291.2</td>
<td>Alcohol-Induced Persisting Dementia</td>
</tr>
<tr>
<td>291.1</td>
<td>Alcohol-Induced Persisting Amnestic Disorder</td>
</tr>
<tr>
<td>V71.01</td>
<td>Adult Antisocial Behavior</td>
</tr>
<tr>
<td>300.4</td>
<td>Dysthymic Disorder</td>
</tr>
<tr>
<td>312.34</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>309.81</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>304.10</td>
<td>Sedative, Hypnotic, or Anxiolytic Dependence</td>
</tr>
</tbody>
</table>

### Axis II:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>301.7</td>
<td>Antisocial Personality Disorder</td>
</tr>
</tbody>
</table>